Indiana's Children's Health Insurance Program Annual Evaluation Report

April 1, 2005

EP&P CONSULTING, INC.

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EXECUTIVE SUMMARY

Indiana's Children's Health Insurance Program (CHIP) offers the State a funding mechanism for receiving enhanced federal subsidies to provide health insurance to children who are not eligible for Medicaid. Now in its eighth year, the program is starting to show signs of maturity.

- Phase I, which began July 1, 1998, expanded Medicaid to children below the age of 19 with family incomes of no more than 150% of the Federal Poverty Level (FPL). This phase is a Medicaid expansion and does not require members to pay monthly premiums. Enrollment in this portion of CHIP was 47,254 in December 2004 and growth was flat when compared to enrollment in December 2003.

- Phase II, which began January 1, 2000, is a non-Medicaid premium-share program designed to provide coverage to children with family incomes above 150% up to 200% of the FPL. Enrollment in this portion of CHIP was 18,827 in December 2004 and grew 19% from the enrollment in December 2003.

The composition of Indiana's CHIP has changed since the beginning of the program. Whereas teenagers comprised the highest percentage of enrollees in the initial years, the distribution by age group is looking more like the distribution in the overall Hoosier Healthwise child population, with the exception that few infants are enrolled in CHIP because they are already eligible for Medicaid. The average period of enrollment in CHIP also grew slightly in 2004 to 10 months as opposed to nine months in 2003.

The delivery of services has also changed over the course of the program's history. As more counties in Indiana become mandatory RBMC counties as well as additional MCOs contracting with the State beginning in 2005, so too has the enrollment of children in CHIP migrated from the Primary Care Case Management (PCCM) delivery system to the Risk-Based Managed Care (RBMC) delivery system. In PCCM, a single doctor is responsible for the management of a child's health care. In RBMC, a managed care organization (MCO) is responsible for this care management. About half of all children in CHIP are now enrolled in the RBMC system. Because of contractual monitoring requirements imposed on the MCOs, this movement of the population has allowed for a more concerted focus on well-child visits and immunizations for children as well as overall increases in the utilization of primary care visits.

This is the fifth evaluation of Indiana's CHIP conducted by EP&P Consulting, Inc. (EP&P). This year's report highlights trends in enrollment and services used by children in CHIP during calendar year (CY) 2004. Data from 2002 and 2003 is often shown for trend analyses. As was the case in previous years, this annual evaluation report includes both original analyses of eligibility and claims data as well as analyses of existing Hoosier Healthwise monitoring reports. Service utilization trends of children in Indiana's Medicaid program as well as available national CHIP and Medicaid data have been used as comparison benchmarks.

Since so few children under age one are enrolled in CHIP (about 200), they have been excluded in all comparative data to the Medicaid child population in Hoosier Healthwise.

The questions at the outset of this year's CHIP evaluation process included:

- How does service utilization of children in CHIP compare with that of children in the Medicaid program (both in terms of the amount of services being utilized and the types of services)?

- Does service utilization vary between children enrolled under Phase I of CHIP (the Medicaid expansion) versus Phase II of CHIP (the premium share program)?

- How do the expenditures for services compare among children in CHIP Phase I, CHIP Phase II and Medicaid?

The findings of the annual evaluation report for the CHIP program for CY 2004 are very similar to the findings of the previous year. There were no systemic issues that affected enrollment into the CHIP or CHIP children's access to services. Available data also showed that the families of CHIP children gave the program higher marks for overall satisfaction than Medicaid members and higher than national studies for similar populations. Over 90% of parents rated their health plan as "excellent" or "very good", and similar percentages were found for ratings of their child's personal doctor.

KEY FINDINGS

- CHIP expenditures per member per month are lower than expenditures per member per month for Medicaid children. This is true for children enrolled in both the PCCM/FFS delivery systems as well as those enrolled in the RBMC delivery system. For primary services (general hospital, physician, and pharmacy), CHIP children cost the State about 5% less on average per month than Medicaid children. When other services (including mental health-related services) are included in the comparison, CHIP children cost the State significantly less—about 20% less—on average each month than Medicaid children. These savings are even higher when you consider that Indiana receives 73.6 cents for every dollar spent on a CHIP child from the federal government and 62.3 cents for every Medicaid-enrolled child.

- For services provided in both the PCCM/FFS and the RBMC delivery systems, CHIP expenditures per member per month for the RBMC delivery system ($72 PMPM) are $9 less than per member per month expenditures for the same services delivered to the PCCM and FFS populations ($81 PMPM).

- The distribution of expenditures across categories of service for the PCCM and FFS populations in CHIP have not changed significantly between SFY 2003 and SFY

2004. Pharmacy expenditures have increased at a higher pace than other service categories.

- Indiana has a similar distribution of CHIP expenditures among major services (hospital, physician, pharmacy, and dental) as compared to other states' CHIP programs in its region.

- When measured on a claims per 1,000 enrollees level, children in the RBMC delivery system of CHIP have higher utilization rates for primary medical visits and dental services than children in PCCM and FFS delivery systems, but lower rates of utilization for hospital and pharmacy services.

- In CY 2004, per member per month expenditures for CHIP Phase I children were over $30 higher than those for CHIP Phase II children.

- CHIP Phase II children have utilization rates that are either similar to CHIP Phase I children or below CHIP Phase I for all service categories. These differences in utilization explain at least some of the difference in PMPM expenditures between the programs.

- Except for hospital services (where the age groups are relatively equal), teenagers are responsible for higher average claim costs than younger children.

- The most expensive service for both CHIP Phase I and CHIP Phase II children (measured on a per member per month basis) is pharmacy services. The same is true for children in Medicaid, although mental health services are almost as high for Medicaid children, whereas they represent less than 10% of total service payments in the CHIP budget.

- Overall, about half of children enrolled in CHIP have used services by doctors designated as primary care doctors in both calendar year 2003 and calendar year 2004, regardless of the delivery system they are enrolled in. Children are more likely to use these services when they are younger (under age five).

- About 80% of children in the PCCM and FFS delivery systems have seen some type of physician (either a doctor defined as a primary care doctor or one that is not) in CY 2003 and CY 2004, while about 70% of children in RBMC delivery system have seen one of these types of providers.

- When compared to national trends for Medicaid managed care plans, Indiana's MCOs rank consistently with national figures on children's access to primary care and well-child visits. However, immunization rates for Indiana's MCOs are lower than national trends. It is unclear without further review if a lower rate of children in Indiana are receiving immunizations or if these services have just not been reported.

RECOMMENDATIONS FOR FURTHER RESEARCH

1. ***Develop a targeted outreach to increase well-child visit and immunization rates.*** Most of the MCOs in the RBMC delivery system as well as Prime*Step* (the PCCM program) found that the rate of well-child visits for all age groups were in line with median levels for other Medicaid managed care plans nationwide. Immunization rates, however, were often below national levels (at least as reported). One issue with the immunization rates reported is that they are not all reported directly to the Office of Medicaid Policy and Planning (which oversees Hoosier Healthwise) or to the CHIP Office. Many immunizations are conducted and recorded through the Indiana Department of Health. Although the implementation of an immunization registry has shown marked improvement in the immunization rates, the finding that these rates are below national levels may not be that the immunizations did not occur. Rather, it may be that they just have not been reported to the OMPP and the CHIP Office.

   EP&P recommends that the CHIP Office closely monitor the efforts of the managed care plan organizations in developing a targeted outreach program to parents of children enrolled in CHIP to encourage getting their children immunized and to receive an annual well-child visit as well as to follow-up on whether these took place. The MCOs have developed a mailing to parents of children in the target population who are due for recommended immunizations—namely, children that are infants through age two. As of December 2004, there were 2,484 children in this age group in CHIP Phase I and 2,655 children in CHIP Phase II. The CHIP Office is encouraged to measuring the impact of these mailings by determining if immunizations appear in utilization reports after the outreach was conducted to parents. If, for example, immunizations were not given within three months of the targeted mailing, the CHIP Office should work with the MCOs to make follow-up calls to the parents and PMPs of children who have not been immunized.

2. ***Track children originally enrolled in the Fee For Service (FFS) delivery system to their final "medical home".*** The policy in Hoosier Healthwise is that upon being informed that they are eligible for CHIP, a child's parents have up to 30 days to decide who the child's PMP will be. As a result, most children are temporarily enrolled in the FFS delivery system upon first being determined eligible for CHIP or Medicaid. By adding two new MCOs in January 2005 and adding more counties to be mandatory RBMC enrollment counties, the OMPP and CHIP have already made great strides in reducing the number of children that are enrolled in FFS even temporarily.

   EP&P has found, however, that the eligibility data is showing that some children are remaining in FFS for more than 30 days, possibly many months. *EP&P recommends that, for those still enrolled in FFS beyond 30 days, the CHIP Office should work to find out whether this is a data reporting issue or if children are in fact still in FFS. If children are remaining in FFS beyond 30 days, the CHIP Office should aim to understand the reason why this is occurring.* Specific recommended steps are detailed in Chapter VI of this report.

CHAPTER I
OVERVIEW OF INDIANA'S CHILDREN'S HEALTH INSURANCE PROGRAM

EP&P Consulting, Inc. (EP&P) was hired by the Office of the Children's Health Insurance Program (CHIP) to conduct the independent evaluation of the Indiana CHIP as required by Legislature. This is the fifth annual evaluation conducted by EP&P. During this time, Indiana's CHIP has changed in many ways that are similar to changes occurring nationally in CHIP programs, while other changes are Indiana-specific.

Nationally, CHIP programs are seeing enrollment that is beginning to level off and in some cases remain flat. Indiana is no exception, although growth in the portion of the program for higher-income families who pay monthly premiums into the program continued to grow at a steady pace in 2004.

Specifically in Indiana, a large composition of the CHIP was comprised of children in the Medicaid expansion of the program that were born before October of 1983. These children have all "aged out" of the CHIP since they have turned age 19 and are no longer eligible. As a result, the composition of children by age group in Indiana's CHIP is now much more similar to that found in the Medicaid portion of Hoosier Healthwise. The only exception to this is that there are very few infants enrolled in the CHIP since they are already eligible for Medicaid. Understanding the composition of the enrollees in CHIP helps to better understand utilization and expenditure trends in the program, as will be detailed in Chapter IV.

This chapter provides a brief background of the national CHIP program, how Indiana's CHIP was designed, who is enrolled, how services are delivered, and issues affecting CHIP programs nationally and in Indiana. Later chapters in this evaluation address enrollment trends, access to services, utilization of services, cost trends and quality monitoring.

The State Children's Health Insurance Program (SCHIP) at the Federal Level

The State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act. Under SCHIP, states could develop programs offering health coverage to uninsured children up to age 19 in families who are not eligible for Medicaid. In implementing SCHIP, states had the option of providing benefits by expanding their existing Medicaid program, by establishing a separate non-Medicaid program, or through a combination of these two program designs. Like 20 other states, Indiana has a "combination" program. Children are determined eligible based upon a family's income level. These income limitations vary across the states based on each state's SCHIP design. Income thresholds range from below 200% of the Federal Poverty Level (FPL) up to 350% of the FPL. Indiana is one of 25 states where eligibility coverage is offered to children with family incomes up to 200% of the FPL, or $37,700 for a family of four in 2004.

Similar to Medicaid, Title XXI is a joint federal-state funded program with states receiving federal-matching dollars. Title XXI offers states a federal allotment for their SCHIP programs. The amount the federal government pays to each state depends on the state's SCHIP federal matching rate up to a pre-defined annual cap. The SCHIP federal matching rate is a percentage of the total program costs that the federal government will pay. (The term "enhanced" is often used when referring to the SCHIP federal matching rate because the SCHIP matching rate was set at a higher percentage than the Medicaid matching rate as an incentive for states to participate in the Title XXI program.)

The SCHIP federal matching rate differs from state to state because it was originally based on a calculation of the state's share of low-income and uninsured children. A state's share of low-income and uninsured children is determined through estimates from the Current Population Survey, conducted by the U.S. Census Bureau. A state cannot receive a matching rate of more than 85% and cannot receive an annual payment of less than $2 million. Indiana's SCHIP federal matching rate was 73.62% in Federal Fiscal Year (FFY) 2004, meaning that for every dollar spent on the Indiana CHIP, state money was used to cover 26.38% of the expenditures and the federal government paid for the remainder. This federal match rate for CHIP compares to Indiana's regular Medicaid match rate of 62.32% for FFY 2004.

Overview of Indiana's Children's Health Insurance Program

Indiana's CHIP was designed and implemented in two phases. Phase I was designed as a Medicaid expansion. Phase I began in October 1997 and extended Medicaid eligibility to uninsured children not previously eligible for Medicaid who:

- Were born before October 1, 1983 and
- With family incomes up to 100% of the Federal Poverty Level (FPL); 100% FPL in 2002 was $18,100 for a family of four

The last of these children enrolled in CHIP reached the age of 19 on September 30, 2002 and, therefore, have not been in the program for over two years now.

In July 1998, this Phase I Medicaid expansion continued by extending eligibility to a second group of children:

- Uninsured children from age one through age five with family income between 133% and 150% of FPL who were not previously eligible for Medicaid; and
- Uninsured children from age six through age 18 with family income between 100% and 150% of FPL who were not previously eligible for Medicaid

Throughout the remainder of this report this first phase of Indiana's implementation of its CHIP will be referred to as CHIP Phase I. Enrollment in CHIP Phase I in December 2004 was 47,254 children, a decline of 1% since December 2003.

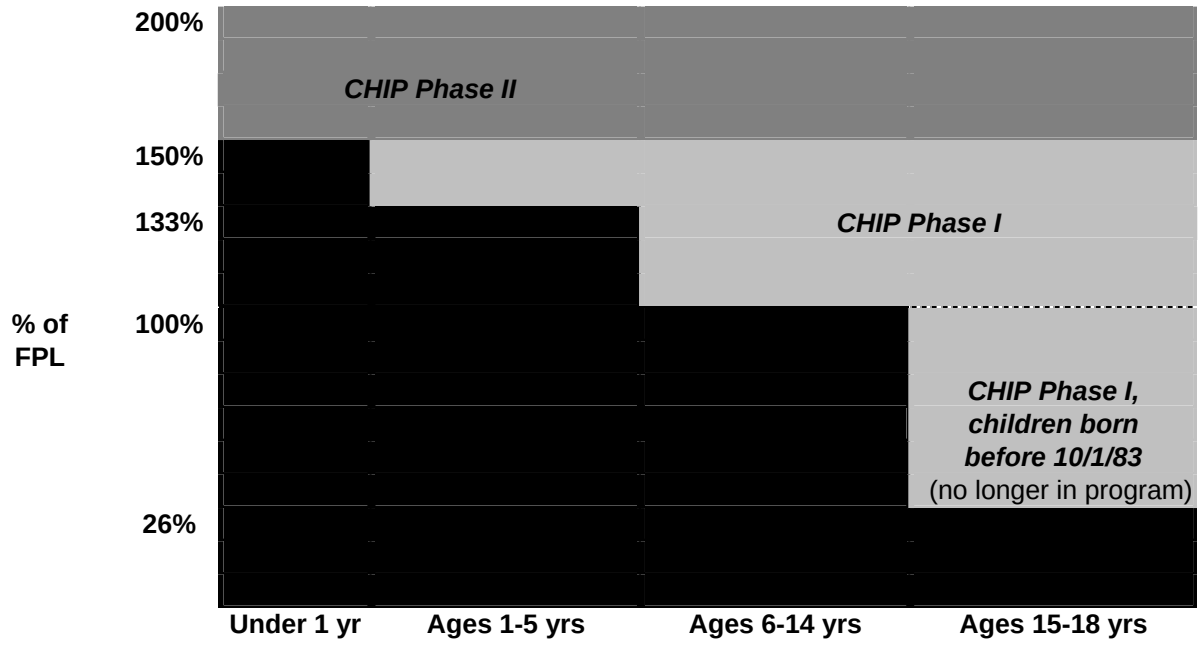
Phase II of Indiana's CHIP was designed as a state-specific, non-Medicaid expansion. Implemented in January 2000, this phase further expanded access to health care coverage by extending eligibility to:

- Uninsured children from birth through age 18 and
- With family income above 150% and up to 200% of FPL

Because the second phase is a state-defined program, the State had more flexibility in designing the program. The State used this flexibility to create a package that differs slightly from the Medicaid managed care benefit package and requires members to pay premiums and co-payments. Also, because this phase is not part of Medicaid, coverage is not an entitlement. In addition, the benefit package does not include all of the services required under Medicaid. *This second phase of Indiana's CHIP implementation will be referred to throughout the remainder of the report as CHIP Phase II.* As of December 2004, enrollment in the CHIP Phase II was 18,827 children, an increase of 19% since December 2003.

Overall program enrollment in both phases of Indiana's CHIP totaled over 66,000 at the end of 2004.

The diagram below illustrates the "stair-step" eligibility process for children in CHIP.



How Services are Delivered in Indiana's CHIP

Children enrolled in both the Medicaid expansion (CHIP Phase I) and the State-Defined Program (CHIP Phase II) portions of Indiana's CHIP receive health care services through the existing Medicaid delivery system, Hoosier Healthwise.

The Hoosier Healthwise delivery system is a multi-faceted delivery system, including two managed care delivery systems existing side-by-side – a primary care case management (PCCM) system and a risk-based managed care (RBMC) system, and a fee-for-service (FFS) system.

- Under the PCCM delivery system, the State contracts with primary medical providers (PMPs), and the PMPs provide or authorize most preventive and primary care services. Certain services, including mental health, family planning, dental, pharmacy, and transportation do not require PMP authorization. Providers are paid a $3.00 per member per month case management fee for care management for children and medical services are paid on a fee-for-service, or "as used" basis.

- Under the RBMC delivery system, the State contracts with managed care organizations (MCOs) to provide comprehensive preventive and primary care services. MCOs are paid a capitation rate per member per month, regardless of whether or not members utilize services. The MCOs then contract directly with PMPs and other providers either under a capitation or a FFS arrangement. Certain services, including dental services and services delivered by mental health providers, are not covered under the capitation rate.

- When members first become eligible for Hoosier Healthwise managed care, there is a 30-day period of time referred to as the "Fee-For-Service" (FFS) window. During this time period, members are covered by Hoosier Healthwise but are not yet enrolled in a managed care program (PCCM or RBMC). The FFS window allows members time to review their coverage options and to select a PMP. It also provides time for the selected physician to receive notification about his/her selection as the member's PMP. This FFS window accounts for the majority of members and utilization identified as FFS within this evaluation. Within the FFS system, a member can receive services from any doctor participating in the Hoosier Healthwise program. The Hoosier Healthwise program enrolls children in either the PCCM or RBMC delivery systems so that they may be linked with a PMP.

In the majority of counties, the selection of a primary medical provider determines the delivery system from which a child receives services. For example, when children are determined eligible for Hoosier Healthwise, their family selects a primary medical provider (referred to as a PMP). The child is then enrolled in the delivery system in which the PMP participates. In 13 counties, enrollment is required in the RBMC delivery system. Members have the option of choosing a PMP from those MCOs that participate in the RBMC delivery system in their county.

Administration of Indiana's CHIP

The State's Family and Social Services Administration (FSSA) has a number of divisions involved in the operation of Indiana CHIP:

- The Office of the Children's Health Insurance Program (the CHIP Office). Public Law 273-1999, the legislation authorizing Phase II of CHIP, created the CHIP Office and charged it with the responsibility of designing and administering Phase II.

- The Office of Medicaid Policy and Planning (OMPP) is the designated single state agency for Medicaid. The Hoosier Healthwise program, which includes CHIP, is operated by the Managed Care unit of the OMPP.

- CHIP eligibility determination is conducted by the Division of Family Resources.

Issues Impacting CHIP Programs Nationwide and in Indiana

Funding for CHIP programs from the federal government is provided through a matching of state dollars up to a pre-defined annual cap. The annual allotments for each state were defined in the BBA of 1997. Due to federal budget constraints, annual allotments were not evenly distributed across the ten-year duration of the SCHIP authorization. In federal years 2002, 2003 and 2004, allotments were 26% below the allotments in the first four years of the initiative. This is commonly known as the "CHIP dip". Allotments go back to pre-2002 levels starting in 2005. Exhibit I.1 on the next page shows the federal annual SCHIP allotments and Indiana's allocation.

Because some state CHIP programs did not realize the potential level of enrollment that they had anticipated in the initial years of the program, many states found that they had excess funding available from these initial years. States have been allowed to save allotments from prior years for use in one of three years starting with the initial allotment year. Because Indiana had a large enrollment in CHIP at the outset, it was able to spend all of its allotments in the early years. In fact, the federal government redistributed monies unused by some states to higher utilizers of funds in other states. Indiana benefited from this redistribution by receiving an additional $48 million from FFY 1998 redistributed funds and $105 million from FFY 1999 redistributed funds. However, due to strict timeframes to spend this money, $53.5 million of this money was reverted back the federal government in 2003 and 2004.

These varied mechanisms for redistribution of funds across states are essentially a moot point now that the CHIP dip has taken place. In 2004, spending in 36 states exceeded their allotments. In fact, by FFY 2006, 14 states are expected to face federal SCHIP funding shortfalls and by FFY 2007 this number will increase to 19 states (Source: Kaiser Commission on Medicaid and the Uninsured, *Financing Health Coverage: The State Children's Health Insurance Program Experience*, February 2005).

Exhbit I.1
Annual Federal SCHIP Allotments and Indiana's Allotments

Federal Fiscal Year	National Allotment (in millions)	Indiana's Allotment (in millions)
1998	$4,200	$71
1999	$4,200	$70
2000	$4,200	$63
2001	$4,200	$60
2002	$3,100	$47
2003	$3,100	$54
2004	$3,200	$54
2005	$4,100	$73
2006	$4,000	$73
2007	$5,000	$73

Source for Federal Allotments:
Financing Health Coverage: The State Children's Health Insurance Program Experience
Kaiser Commission on Medicaid and the Uninsured, February 2005

Source for Indiana Allotments:
Office of Medicaid Policy and Planning Budget Analysis Report for Fiscal Years 2004 through 2007
December 14, 2004

Indiana is fortunate in that it is expected that there will be sufficient federal matching funds available to continue Indiana's CHIP with the current eligibility criteria until SFY 2008 (Source: *OMPP Budget Analysis Report*, December 14, 2004). Nineteen other states are expected to run out of funds in FFY 2007.

To counteract this funding imbalance from the federal government, eight states imposed freezes on enrollment to hold back CHIP program expenditures (Kaiser). At this point, it does not appear that Indiana will face this issue unless enrollment grows beyond anticipated levels or if federal funding amounts change in the final years of the initial SCHIP allocation.

CHAPTER II
ENROLLMENT TRENDS FOR CHILDREN IN HOOSIER HEALTHWISE

INTRODUCTION

This chapter reviews the changes in enrollment for children in CHIP Phase I (CHIP Package A), CHIP Phase II (CHIP Package C), and the Medicaid portion of Hoosier Healthwise over the last three years. Specific analyses focus on enrollment across a number of parameters within Hoosier Healthwise including:

- Distribution of members by age
- Distribution of members by delivery system
- Distribution of members within regions of the state
- The variation of enrollment between CHIP and Medicaid children at the county level

The chapter begins with an overview of the rate of uninsurance for children in Indiana compared to that of nearby states and the national average.

KEY HIGHLIGHTS

- Indiana's uninsurance rate of 20% for children in families below 200% of the federal poverty level (as measured from 2002 to 2003) is lower than the national average (21%), but slightly higher than the average among neighboring states (from 12% to 20%).

- Enrollment growth in CHIP Phase I has been flat over the past few years, while CHIP Phase II is growing quickly (19% in 2004). This difference is probably the result of the difference in the length of time each portion of the program has been in existence.

- The average age of children in CHIP Phase I (slightly over 10 years) is higher than the average ages of children in either CHIP Phase II (slightly over 8 years) or Medicaid (slightly over 7 years), primarily due to differences in eligibility criteria between the three programs.

- The increasing number of counties where RBMC enrollment is mandatory and the general transition towards managed care led to high growth rates in RBMC enrollment in 2004 and, alternatively, negative growth in the PCCM delivery system.

- The average period of enrollment for members in CY 2004 is consistent across programs and age groups at about 10 months, a slight increase from CY 2003.

SPECIFIC ANALYSES

How does Indiana's child uninsurance rate compare to the national average and other states?

For all children age 18 and younger, Indiana's uninsurance rate of 10% is slightly lower than the national average of 12% and ranks in the middle among all states (27th out of 51 states including the District of Columbia). Indiana has a high rate of insurance from employer-based policies and individual policies compared to all states, resulting in Indiana having a comparatively lower rate of insurance for children in the Medicaid and CHIP programs.

Exhibit II.1
Distribution of All Children Aged 0 to 18 by Insurance Status, 2002-2003

	U.S.	Indiana	Indiana Ranking Across 51 States*	Compared to other border/nearby states					
				Illinois	Kentucky	Michigan	Minnesota	Ohio	Wisconsin
Employer-based	58%	67%	9	64%	55%	65%	71%	67%	66%
Individual policies	4%	5%	17	5%	5%	3%	5%	3%	4%
Medicaid/CHIP	25%	18%	41	20%	26%	25%	17%	21%	23%
Other**	1%	1%	39	1%	2%	0%	0%	1%	1%
Uninsured	12%	10%	27	11%	12%	7%	6%	9%	7%

*Includes 50 states and District of Columbia

**Includes Medicare and insurance through military

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured

Estimates based on pooled March 2003 and 2004 Current Population Survey (U.S. Census Bureau)

Numbers are weighted to the 2000 Census

When comparing Exhibit II.1 to the same data from last year's evaluation, Indiana's employer-based insurance coverage has decreased (from 69% last year to 67% this year) and this has caused the percentage coverage by Medicaid or CHIP to increase (from 15% last year to 18% this year). The uninsured rate has fallen slightly, from 11% last year to 10% this year, for the child population.

Within its region, Indiana is not on either extreme for any of the four categories of insurance coverage. Indiana's uninsurance rate is in the middle of all the border or nearby states studied. Indiana and Minnesota have the lowest rates of insurance through the Medicaid or CHIP programs in the region, but this may partially stem from the fact that both states have higher insurance rates from employer-sponsored insurance.

Considering just low-income children (below 200% of FPL), Indiana's relative position among the states studied does not change much (see Exhibit II.2). The uninsured rate of low-income children is slightly below the national average, and Indiana has a lower rate of insurance coverage under Medicaid/CHIP than the national average and nearby states and a higher rate of insurance coverage under employer-sponsored insurance programs.

Despite this higher level of employer-sponsored insurance, Indiana (along with Illinois) has the highest rate of uninsured low-income children in the region. This rate of uninsured has remained

steady for both Indiana and the nation when compared with information reported in last year's report.

Exhibit II.2
Distribution of Low-Income Children (Less than 200% of Poverty) Aged 0 to 18 by Insurance Status, 2002-2003

	U.S.	Indiana	Indiana Ranking Across 51 States*	Compared to other border/nearby states					
				Illinois	Kentucky	Michigan	Minnesota	Ohio	Wisconsin
Employer-based	26%	34%	7	34%	26%	31%	30%	33%	30%
Individual policies	3%	4%	20	3%	4%	3%	6%	3%	5%
Medicaid/CHIP	48%	42%	43	42%	48%	54%	47%	47%	52%
Other**	2%	1%	33	1%	4%	1%	0%	1%	1%
Uninsured	21%	20%	21	20%	18%	12%	17%	17%	13%

*Includes 50 states and District of Columbia

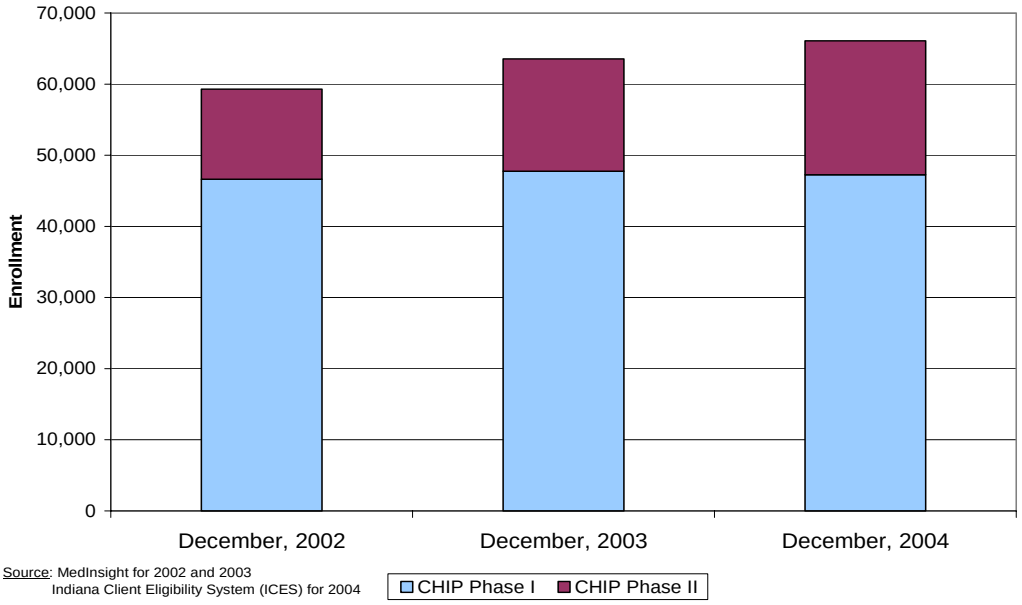
**Includes Medicare and insurance through military

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured
Estimates based on pooled March 2003 and 2004 Current Population Survey (U.S. Census Bureau)
Numbers are weighted to the 2000 Census

What is the growth rate in 2004 of the CHIP Program (Phases I and II)?

The growth rate of the CHIP program differs depending on which phase of the program is considered. Growth in Phase I of the program has flattened out between 2003 and 2004. However, enrollment in Phase II of the program continues to increase at a steady rate—19% in calendar year 2004 and 24% in calendar year 2003. When enrollment from both phases of CHIP is combined, the total CHIP program continues to grow, but solely due to gains from CHIP Phase II. Exhibit II.3 shows total CHIP enrollment at the end of calendar years 2002, 2003 and 2004.

Exhibit II.3
Total CHIP Enrollment



Source: MedInsight for 2002 and 2003
Indiana Client Eligibility System (ICES) for 2004

Why is the enrollment between CHIP Phase I and CHIP Phase II so different?

Exhibit II.4 shows the separate growth rates for each phase of the program. If one considers that the two phases are in different stages of development, the difference between the two growth rates becomes less surprising. Phase I was implemented three years earlier than Phase II (1997 compared to 2000), and it also started with a much larger enrollment than Phase II (Phase I started with over 35,000 children in the program; Phase II started with none). Another reason for higher growth in CHIP Phase II may be the reduction in employer-sponsored insurance that the state is facing (refer back to Exhibit II.2).

Exhibit II.4
Growth Rates of CHIP Members by Family Income Levels

Year	CHIP Members Phase I (100% - 150% of FPL)	CHIP Members Phase II (150% - 200% of FPL)	Growth Rate CHIP Phase I	Growth Rate CHIP Phase II
December, 2002	46,616	12,695	-	-
December, 2003	47,779	15,760	2%	24%
December, 2004	47,254	18,827	-1%	19%

Source: MedInsight files for December 2002 and December 2003 figures
Indiana Client Eligibility System (ICES) for December 2004 totals

What are the trends in CHIP enrollment nationwide?

Over CY 2004 there was a large amount of variation in growth rates of CHIP programs between the states (see Exhibit II.5). Five states have CHIP programs that grew faster than 15%, while two have programs that shrunk by 30%. Indiana ranks in the middle of all states in terms of enrollment growth, ranked 22nd (note that seven states are missing due to missing data).

Exhibit II.5
Comparison of SCHIP Enrollment Across States Between 2003 and 2004

State Name	Point In Time Enrollment 4th Quarter 2004	Point In Time Enrollment 4th Quarter 2003	Difference Between 4th Qtr 04 and 4th Qtr 03	Percent Change Between 4th Qtr 03 and 4th Qtr 04
Washington	13,402	8,106	5,296	65%
Idaho	12,953	10,954	1,999	18%
Oklahoma	62,163	53,258	8,905	17%
North Carolina	126,312	109,236	17,076	16%
South Carolina	52,727	45,666	7,061	15%
Montana	10,989	9,641	1,348	14%
New York	417,880	369,485	48,395	13%
Wyoming	3,924	3,494	430	12%
Virginia	65,689	58,715	6,974	12%
Oregon	22,730	20,366	2,364	12%
Kansas	33,100	30,072	3,028	10%
Massachusetts	65,152	59,256	5,896	10%
Maine	14,171	12,930	1,241	10%
South Dakota	10,330	9,494	836	9%
New Mexico	11,016	10,171	845	8%
Iowa	27,516	25,464	2,052	8%
Louisiana	100,244	93,194	7,050	8%
Rhode Island	11,406	10,615	791	7%
West Virginia	24,047	22,410	1,637	7%
Nevada	25,679	24,128	1,551	6%
District of Columbia	3,998	3,767	231	6%
Indiana	**61,551**	**58,088**	**3,463**	**6%**
New Jersey	101,712	97,049	4,663	5%
California	746,807	715,207	31,600	4%
Missouri	89,815	86,143	3,672	4%
Ohio	126,453	123,616	2,837	2%
Pennsylvania	126,555	124,808	1,747	1%
Florida	322,348	322,472	-124	0%
Georgia	189,219	189,966	-747	0%
Mississippi	82,900	83,460	-560	-1%
North Dakota	3,448	3,495	-47	-1%
Delaware	4,984	5,121	-137	-3%
Alabama	60,754	62,449	-1,695	-3%
Arizona	49,375	50,845	-1,470	-3%
Connecticut	14,167	14,640	-473	-3%
Nebraska	22,204	23,066	-862	-4%
Kentucky	49,127	51,844	-2,717	-5%
Alaska	11,674	12,353	-679	-5%
Hawaii	13,592	14,492	-900	-6%
Utah	27,329	30,347	-3,018	-10%
Wisconsin	32,168	37,048	-4,880	-13%
Maryland	89,946	105,050	-15,104	-14%
New Hampshire	6,717	9,542	-2,825	-30%
Texas	355,518	507,281	-151,763	-30%
TOTALS	**3,703,791**	**3,718,804**	**-15,013**	**0%**

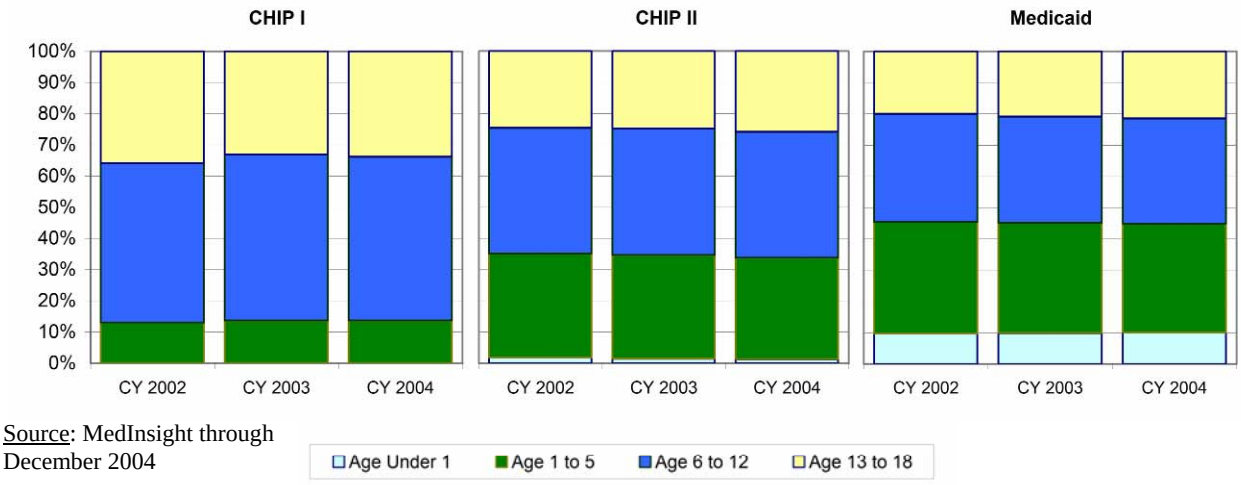
Source: CMS website
Notes: 1. MS, NH, and ND data compared was First Qtr 2004 and Fourth Qtr 2004
2. States with incomplete data (not reported here): AR, CO, IL, MI, MN, TN, VT

How does the age distribution of members in CHIP Phase I compare to the distribution in CHIP Phase II and Medicaid?

Exhibit II.6 shows the age distribution of children 18 and under enrolled in CHIP Phase I, CHIP Phase II, and Medicaid across the past three years. Though the distribution of members across the age groups does vary, the differences are probably more the result of different eligibility requirements for each of the programs than of any other factors. For instance, children in their first year of life with family incomes up to 150% of the Federal Poverty Line (FPL) are covered under Medicaid, meaning no children under age one are enrolled in CHIP Phase I.

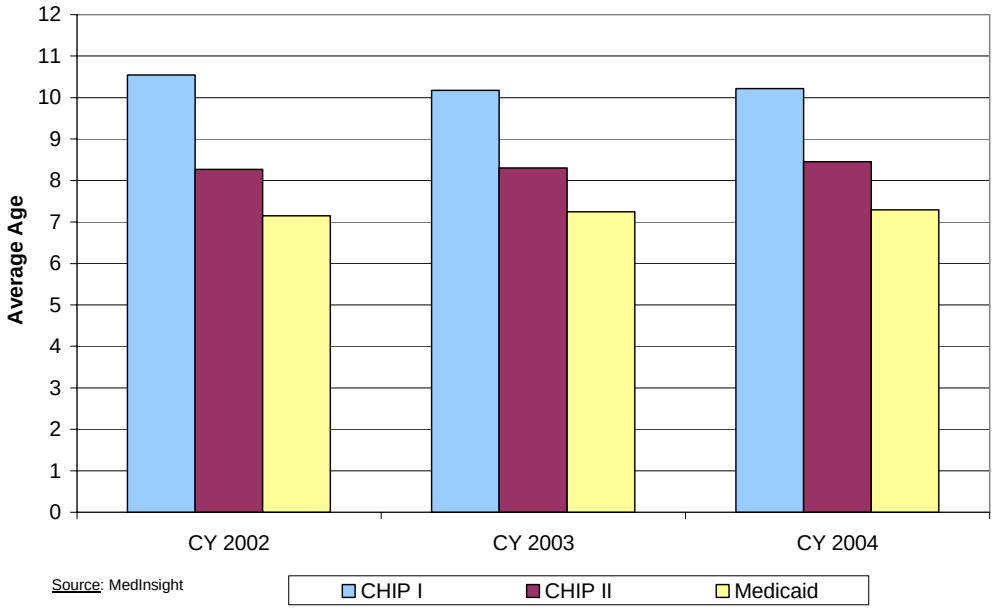
Furthermore, children ages one through five in families up to 133% of FPL are still covered under Medicaid, which only leaves the gap between 133% and 150% of FPL for the age group in CHIP Phase I. Not until a child reaches age six does Medicaid eligibility get reduced to 100% of the FPL. At this point, the distribution of children ages six through 18 is similar between CHIP Phase I, CHIP Phase II and Medicaid. It is not surprising, therefore, that the average age of children in CHIP Phase I is higher than that of CHIP Phase II or Medicaid (see Exhibit II.7 on the next page). Medicaid has the youngest child population of the three groups because it has almost all of the children under age one.

Exhibit II.6
Age Distribution of Children Age 0-18 by Program Type



Source: MedInsight through December 2004

Exhibit II.7
Average Age of Enrollees by Program



Source: MedInsight

What is the distribution of enrollment by delivery system between CHIP Phase I, CHIP Phase II, and Medicaid members?

The Hoosier Healthwise program (both CHIP and Medicaid) has made a concerted effort in the past three years to enroll more children in the Risk-Based Managed Care (RBMC) delivery system. Enrollment in RBMC is now mandatory in 13 of Indiana's counties. Under the RBMC system, members are enrolled with doctors who are affiliated with managed care organizations. This system, in conjunction with the Primary Care Case Management (PCCM) delivery system, comprises Indiana's managed care program. The fee-for-service (FFS) portion of the program, however, remains relatively high, especially for CHIP Phase II. There are two reasons why children may be enrolled in the FFS portion of the program:

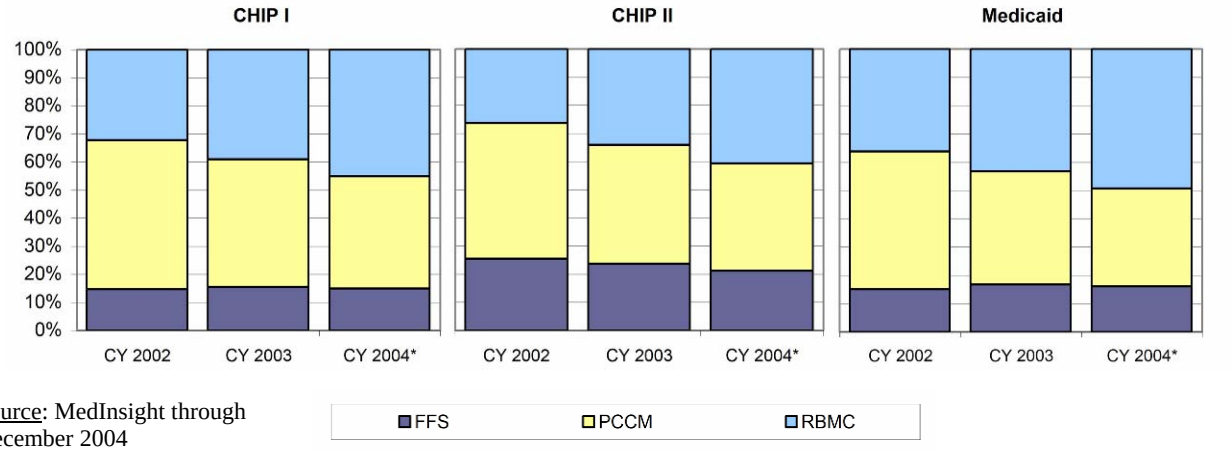
- The primary reason is that they are enrolled in the FFS system for a temporary period when first enrolling in Hoosier Healthwise before they have chosen a doctor (commonly referred to as the "fee-for-service window")

- They are affiliated with doctors in rural areas of the state where there is less managed care participation

Other than a slightly higher percentage of FFS enrollment in CHIP Phase II, enrollment patterns across delivery systems are very similar between CHIP Phase I, CHIP Phase II and Medicaid children. More significant changes are found when the distribution by delivery system is compared across years. Since the FFS population has remained relatively constant from year to year, the increases in RBMC enrollment are coming entirely out of the PCCM population. This

finding supports the assertion that the FFS population is composed mostly of new enrollees, who then later move into PCCM or RBMC.

Exhibit II.8
Distribution of Enrolled Members by Delivery System
Across Calendar Years 2002, 2003 and 2004



Source: MedInsight through December 2004

Growth in the RBMC delivery system has been substantial over the past two years. Exhibit II.9 on the next page shows the growth rates in CY 2003 and CY 2004. RBMC enrollment grew rapidly in 2003 and even faster in 2004, while PCCM had flat growth in 2003 and began to decline in 2004. These growth rates reflect both shifts of enrollment from PCCM to RBMC and new enrollees that enter the program directly into RBMC.

It is expected that overall enrollment in the PCCM portion of Hoosier Healthwise will continue to decline in the coming year for two reasons. First, two new managed care organizations contracted with the state starting in January 2005, enabling more opportunities for members to enroll with doctors in the RBMC delivery system. Second, the state continues to promote the movement of existing members of Hoosier Healthwise out of the PCCM and FFS delivery systems and into the RBMC delivery system by enrolling with doctors associated with one of the five MCOs.

Exhibit II.9
Enrollment Growth Rates by Delivery System
In Calendar Years 2003 and 2004

	CHIP I and II		Medicaid	
Year	PCCM	RBMC	PCCM	RBMC
2003	5%	17%	0%	11%
2004*	-14%	25%	-20%	21%

Source: MedInsight * 10-months of data are included for CY2004.

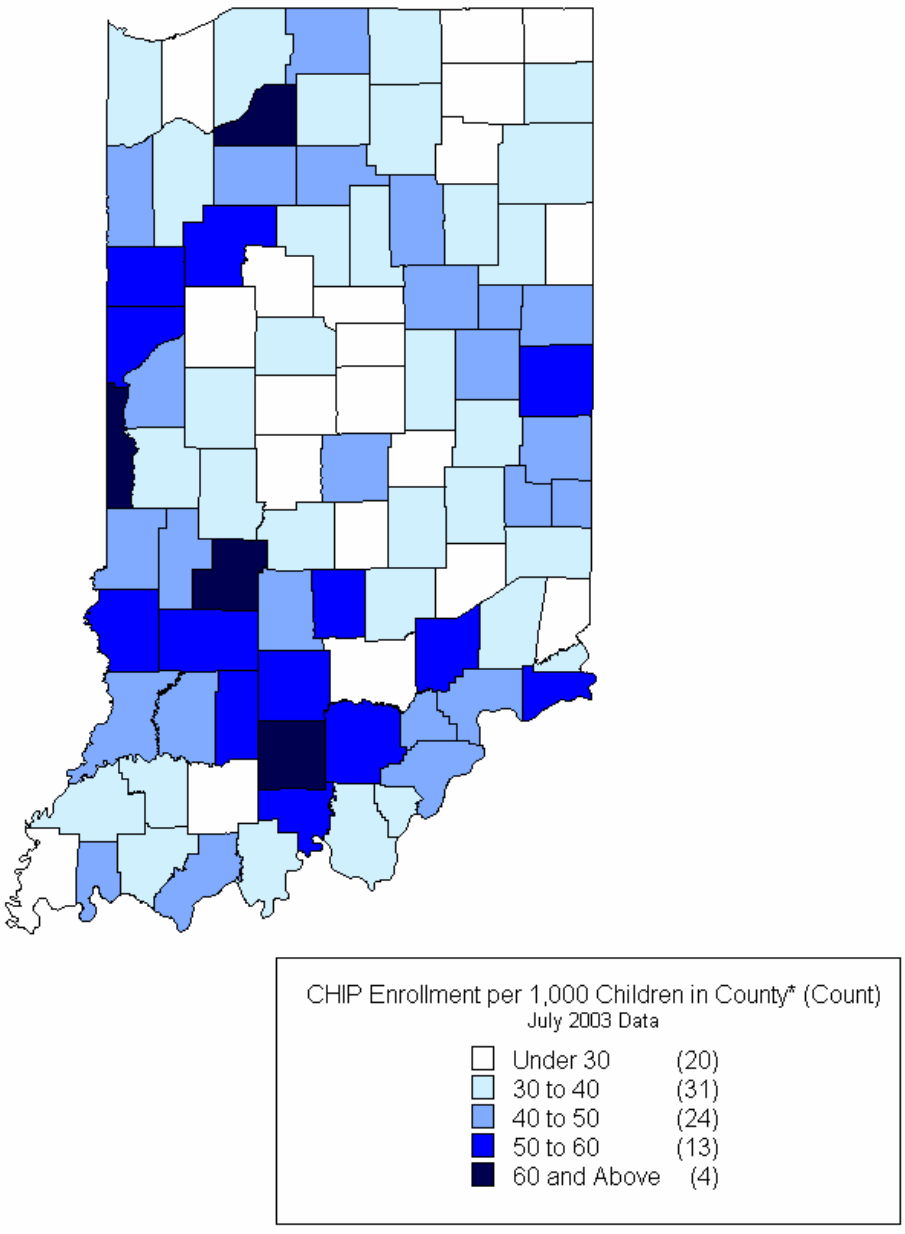
What are the Urban/Rural distribution patterns of CHIP Phase I and II versus Medicaid enrollment for children? Have they changed since last year?

The majority of enrollees in each program live in an urban area. The urban/rural distribution at the end of 2004 was the same as it has been since the end of 2000 with 82% of the CHIP population (Phase I and Phase II) and 86% of the Medicaid population residing in urban counties.

What are the patterns of enrollment in different regions of the state?

Exhibit II.10 on the next page shows that there is some variation in the proportion of CHIP enrollees by county. The total child population (age up to 18) was derived from U.S. Census Bureau data from July 2003 estimates (the most recent available). CHIP enrollment for this time period (both CHIP Phase I and Phase II) were added together and compared to the census figures. Because counties have varied population levels, a measurement of CHIP enrollment per 1,000 children in each county in Indiana was calculated. The darker colors in Exhibit II.10 indicate that a higher proportion of children in the county are enrolled in either CHIP Phase I or Phase II. Four counties have 60 or more children per 1,000 enrolled in a CHIP program, at least twice the rate of the 20 counties with less than 30 per 1,000 enrolled. Of the four counties with 60 or more children per 1,000 enrolled in CHIP, the southernmost one, Orange County, has the highest rate of CHIP enrollment (71 children per 1,000). Hamilton County, in the center of the state, is the county with the lowest rate of CHIP enrollment (13 children per 1,000). In general, counties in the center of the state have low rates of enrollment, while counties in the southern region of the state have higher rates of enrollment.

Exhibit II.10
Map of CHIP Enrollment Per 1,000 Children by County
July 2003

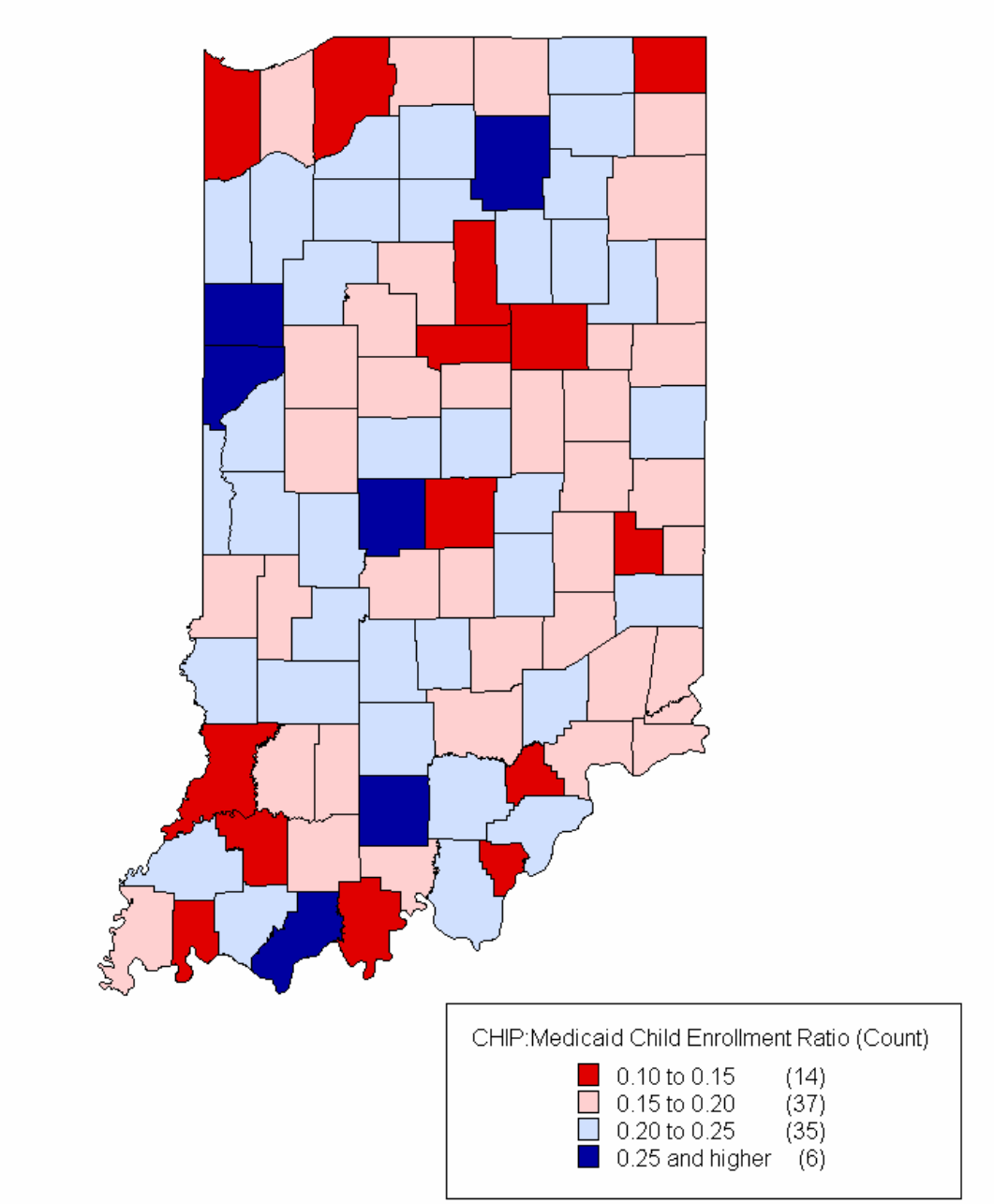


Source: MedInsight and Census data (July 2003)

Are the findings of the measurement of CHIP enrollment per 1,000 in each county related to enrollment of children in Medicaid in the county?

Not really. The map shown in Exhibit II.11 compares enrollment of children in CHIP to enrollment of children in Medicaid within each county in December 2004**.** Red counties have relatively small populations of CHIP enrollees compared to Medicaid enrollees, while dark blue counties have relatively large populations of CHIP enrollees compared to Medicaid enrollees. When compared to Exhibit II.10, this map does not suggest any direct relationship between the CHIP to Medicaid enrollment ratio and any region of the state, nor does it suggest a strong relationship between enrollment rates in CHIP and the relative sizes of the CHIP and Medicaid child populations. Comparing Exhibit II.10 and II.11, high enrollment rates in CHIP do not mean that the CHIP to Medicaid enrollment ratio is also high. In some counties, such as Orange County, high rates of CHIP enrollment correspond to a large CHIP to Medicaid enrollment ratio, but in others, such as Hendricks County, a high CHIP to Medicaid enrollment ratio does not correspond to high rates of CHIP enrollment.

Exhibit II.11
CHIP to Medicaid Child Enrollment Ratio by County



Source: MedInsight through December 2004

How does the average period of enrollment of members compare between CHIP Phase I, CHIP Phase II and Medicaid?

Exhibits II.12 and II.13 show the average number of months children were enrolled in the three Hoosier Healthwise programs for CY 2003 and CY 2004, respectively. Since many children move between the Hoosier Healthwise programs, children were categorized so that the programs are mutually exclusive. Children are only included in the program they were enrolled in most recently in the calendar year. The total number of months is then determined by adding together the number of months the child was enrolled in any of the three programs.

An average period of enrollment between nine and ten months agrees with Indiana's historical average as well as the historical average seen across many states. The data from CY 2004 suggests that this average is rising in Indiana, as the average period of enrollment rose in every age category and for every program type from CY 2003 to CY 2004.

Exhibit II.12
Average Period of Enrollment By Program and by Age Group (in months)
For Calendar Year 2003

	Age 1 - 5 Years	Age 6 - 12 Years	Age 13 and over
CHIP Phase I	9.9	10.0	9.8
CHIP Phase II	9.1	9.3	9.2
Medicaid	10.1	10.1	9.4

Source: MedInsight files through December 2003

Exhibit II.13
Average Period of Enrollment By Program and by Age Group (in months)
For Calendar Year 2004

	Age 1 - 5 Years	Age 6 - 12 Years	Age 13 and over
CHIP Phase I	10.1	10.3	10.0
CHIP Phase II	9.5	9.5	9.5
Medicaid	10.3	10.4	9.6

Source: MedInsight files through December 2004

CHAPTER III
ACCESS

Chapter III provides an analysis of the various ways members can and do access the CHIP program. There are two factors that determine a member's access to services in the program:

- The first is their primary medical provider (PMP). When members select their PMP, they are automatically enrolled in the delivery system with which their PMP has contracted to do business. This could be either the Risk-Based Managed Care (RBMC) system, whereby a PMP contracts with a managed care organization (MCO), or the Primary Care Case Management (PCCM) system, whereby the PMP contracts directly with the State.

- Access may also be affected by the member's geographic location. By July 2004, 13 counties had been designated as mandatory RBMC counties. Therefore, although members still had the option of selecting their PMP if they lived in one of these counties, they had to select a PMP that was contracted with an MCO.

Indiana is gradually implementing mandatory managed care requirements throughout the state. This may impact access depending upon the availability of doctors enrolled with MCOs. It should be noted that as of January 2005, two additional MCOs began contracts with the Hoosier Healthwise program. By having five MCOs participating, the intent is to attract more doctors and provide more access and choice to Hoosier Healthwise members.

EP&P reviewed a number of items related to access—both the options that CHIP members have to obtain services as well as the level of participation among children receiving services. Specific areas include:

- A review of the counties where MCOs currently participate in Hoosier Healthwise

- An analysis of the pediatric PMP panel capacity by county, which measures the availability of pediatricians to CHIP (and all child) members

- An analysis of the percentage of CHIP members that are using specific services, such as hospital, physician, pharmacy, and dental services

- An in-depth review of the percentage of CHIP members that are using physician services based on their age group

KEY HIGHLIGHTS

- Though the number of providers increased from 2003 to 2004 and the number of enrollees per provider decreased during the same period, the number of full pediatric panels (that is, the number of pediatricians that would accept no more patients) increased slightly.

- More members in the RBMC delivery system access PMP physician services and dental services than members in the PCCM and FFS delivery systems, but less RBMC members access outpatient and pharmacy services than members in the PCCM and FFS systems do.

- Overall, about half of children enrolled in CHIP have used PMP services in both calendar year 2003 and calendar year 2004, regardless of the delivery system. Children are more likely to use these services when they are younger (under age five).

- About 80% of children in the PCCM and FFS delivery systems have seen some type of physician (either one defined as a PMP or one not defined as a PMP) in CY 2003 and CY 2004, while about 70% of children in RBMC delivery system have seen one of these types of providers.

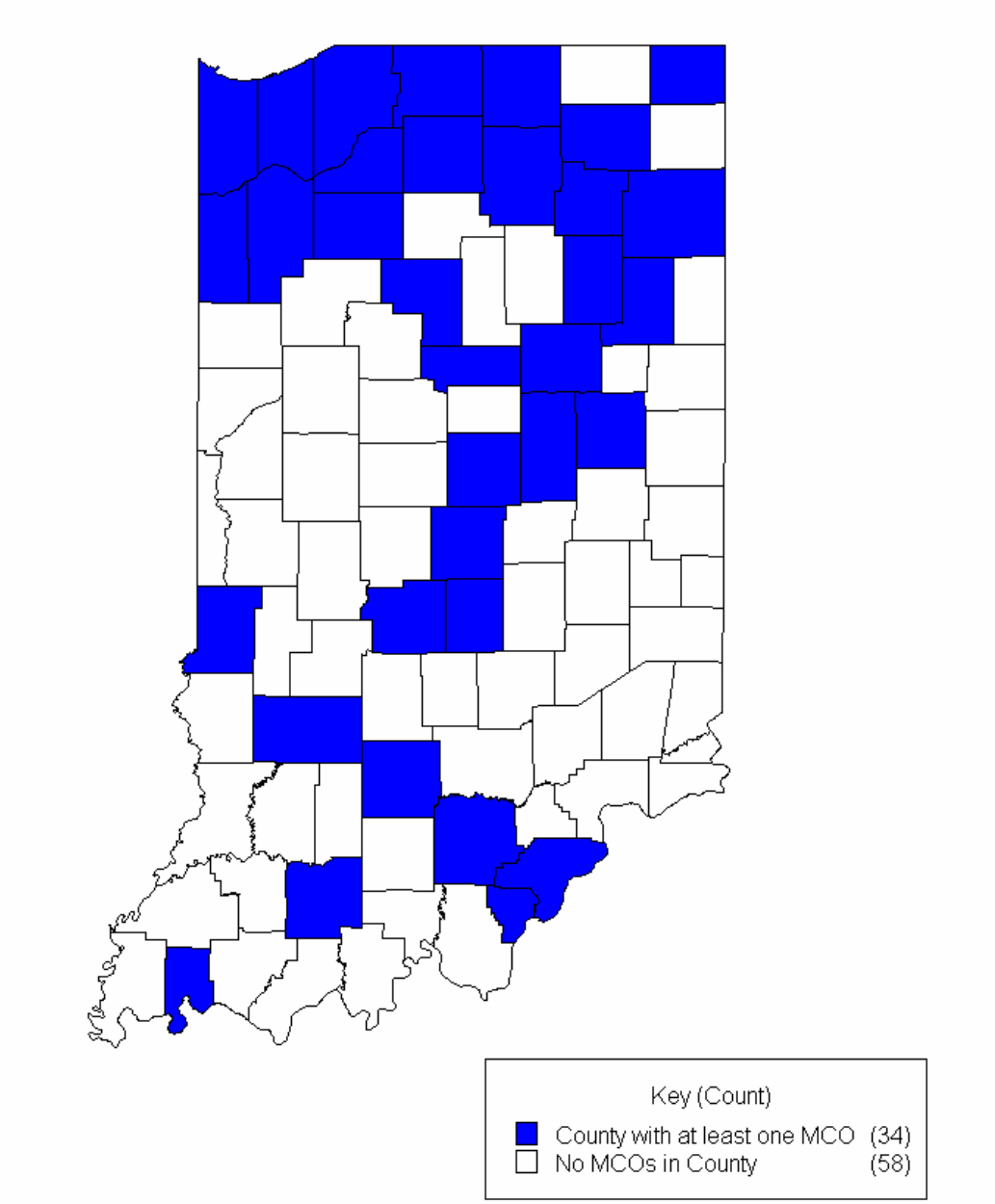
SPECIFIC ANALYSES

How many counties have MCOs that participate in the CHIP program?

As discussed in Chapter II, Indiana continues to transition the CHIP population to the RBMC delivery system from either the PCCM or fee-for-service (FFS) delivery systems. RBMC is paid for through capitation payments to MCOs who are then responsible for managing the health of their members. EP&P has found that the RBMC delivery system tends to increase the access members have to preventative care while lowering overall costs (more details on this will be discussed in Chapter IV- Service Utilization and Expenditure Trends).

For the past three years, Hoosier Healthwise has been phasing in counties to be designated as mandatory RBMC counties, requiring that all CHIP members enroll with a doctor in an MCO. As of July 1, 2004, 13 counties have made this transition. The map on the next page shows the counties that have at least one participating MCO (see Exhibit III.1). Though only 13 counties have mandatory managed care at this time, another 21 counties have managed care options on a voluntary basis for a total of 34 counties in which at least one MCO participates.

Exhibit III.1
Map of Counties with Participating MCOs



Source: OMPP, January 2005

How does pediatric PMP panel capacity vary across the state?

The Office of Medicaid Policy and Planning (OMPP) tracks the number of pediatric primary medical providers (PMPs) enrolled in Hoosier Healthwise each year. This analysis is done to understand not only the total number of available pediatric PMPs, but also to understand the volume of clients these pediatricians are willing to accept and whether or not access to this service is an issue in parts of the state. Pediatric PMPs, like other PMPs, negotiate with the State as to the number of Hoosier Healthwise clients they are willing to accept. This is known as the provider's "panel size". By understanding the total capacity available for this service, the OMPP better understands where they need to target to obtain more pediatric PMPs or negotiate with current providers to increase their panels.

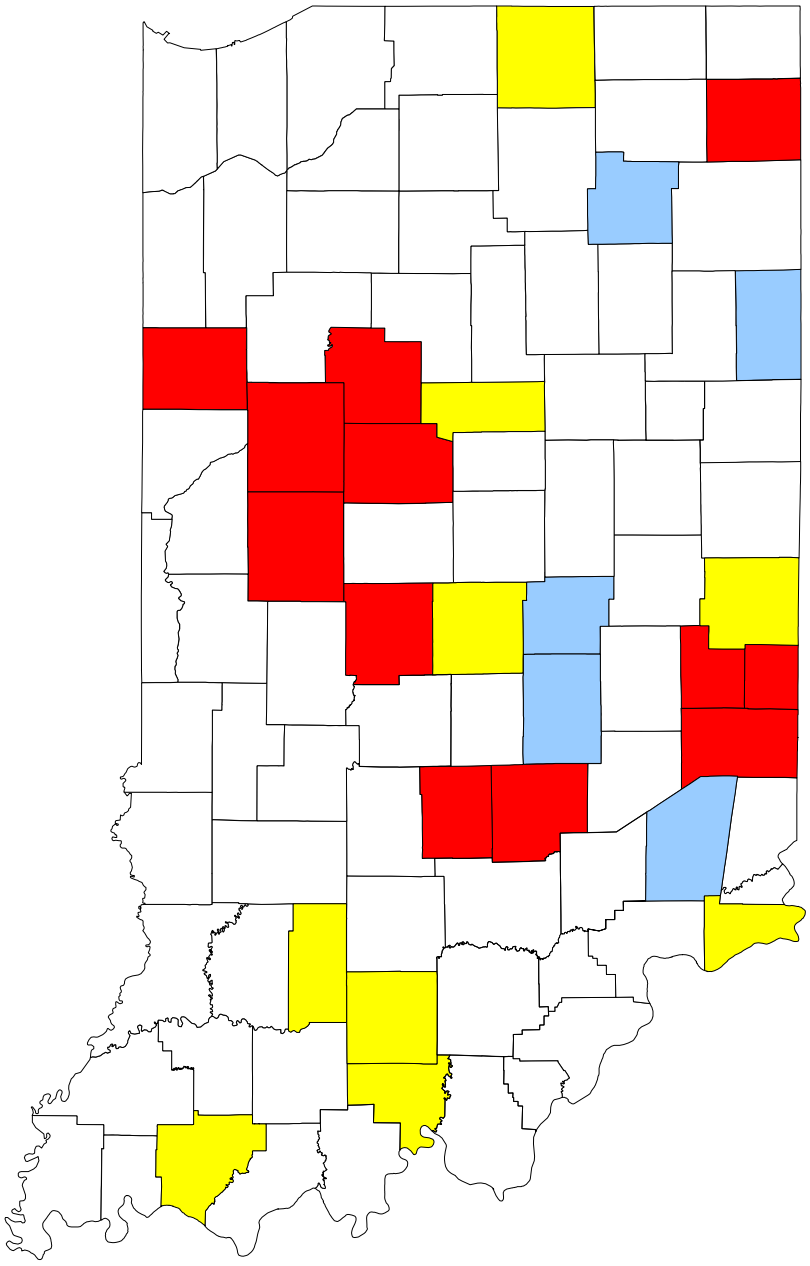
Pediatric PMPs include General Practice, Family Practice, and Pediatrician PMPs, but do not include Internal Medicine, OB/GYNs or PMPs who only treat patients older than 17. Findings from 2004 showed that:

- The number of pediatric providers has increased 4.6% from 1,800 in December 2003 to 1,883 in December 2004.
- The average number of Hoosier Healthwise enrollees per pediatric PMP has decreased 2.7% from 269 in December 2003 to 262 in December 2004.
- Half of the pediatric PMP panels, however, are full. This is a slight increase from 49% in December 2003 to 50% in December 2004. This capacity rate lends itself to concern regarding members' access to care through a pediatric physician.

The map on the next page (Exhibit III.2) examines panel size on a county-by-county basis. The analysis of panel size for Hoosier Healthwise as of January 2005 showed that:

- Twelve counties had full provider panels as of January 2005, including Bartholomew, Benton, Brown, Carroll, Clinton, DeKalb, Fayette, Franklin, Hendricks, Montgomery, Tippecanoe and Union counties. This is a net increase of one county with full provider panels since January 2004. That is, 11 counties reported full provider panels in January 2004, but there are three new counties (Benton, Brown and Carroll) with full provider panels and two counties (Jackson and Ripley) are no longer at full capacity in January 2005.
- A total of 26 counties had panels above 80% full as of January 2005 compared to 23 counties in January 2004. Four were in the Northern region, thirteen in the Central region, and nine in the Southern region.

Exhibit III.2
Measure of Pediatric PMP Panel Capacity By County



Percent Panel

- **100% full or more**
- **90% - 99% full**
- **80% - 89% full**

Source: OMPP, January 2005

Do utilization statistics indicate that CHIP members are accessing services?

Overall, CHIP members in the Phase I and Phase II portions of the program are accessing services at similar rates. The number of unique individuals enrolled in both CHIP phases for the PCCM, FFS and RBMC delivery systems was measured and compared to the number of unique individuals that actually accessed the services. (For the purposes of this analysis, the PCCM and FFS delivery systems were combined.) When the percentage of members that use services is evaluated, only members who have been in the program for at least nine months in a calendar year are considered, because those who have been enrolled for a shorter period than this may not have had an adequate opportunity to use the services. This is especially true for routine preventative care services that are usually only used once or twice a year.

Children often move between CHIP Phase I and Phase II during the year or between delivery systems (e.g. from PCCM to RBMC) during the year. For the purpose of this analysis, children are categorized once, according to which portion of CHIP and which delivery system they were enrolled in at the end of the calendar year.

This review was conducted separately for the services that comprise the majority of utilization and expenditures in CHIP—inpatient hospital, outpatient hospital, PMP services, other physicians that are not designated as PMPs, pharmacy, and dental services. EP&P also compared the rate of use for CHIP children to the children in the Medicaid program. Key findings from this analysis, as displayed in Exhibits III.3-III.6 on the following pages, indicate:

- Pharmacy services are the most commonly used services, regardless of what program or delivery system the enrollee is in. Over 60% of enrollees in both CHIP and Medicaid used this service in both calendar years 2003 and 2004.

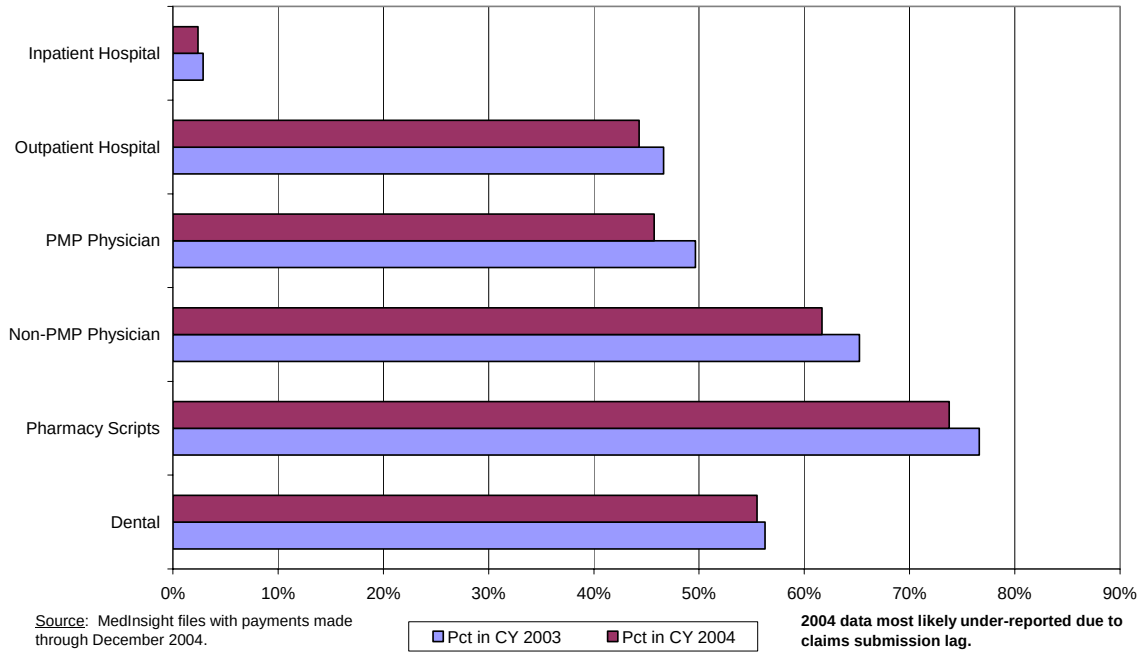
- The patterns of usage between children in CHIP Phase I and CHIP Phase II for those enrolled in the PCCM and FFS delivery systems are nearly indistinguishable.

- Comparing PCCM/FFS to RBMC, CHIP children in the RBMC delivery system are less likely to access pharmacy services and non-PMP services but more likely to access dental and PMP physician services.

- The most significant difference between the CHIP children and Medicaid children is that Medicaid children are less likely to access dental services.

- Only half of the children (all ages, all delivery systems) in the CHIP program are using PMP physician services, which are the source of most well child visits. Access to these services is evaluated in the next section.

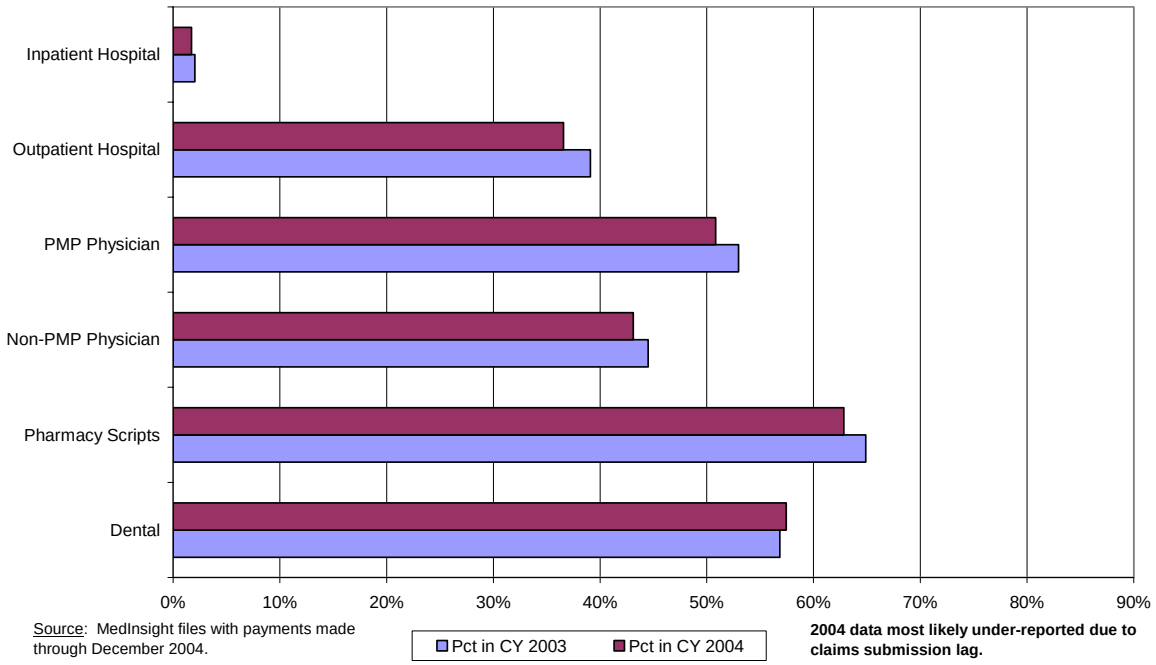
Exhibit III.3
Percent of CHIP Enrollees (Phases I and II) that Used Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: MedInsight files with payments made through December 2004.

2004 data most likely under-reported due to claims submission lag.

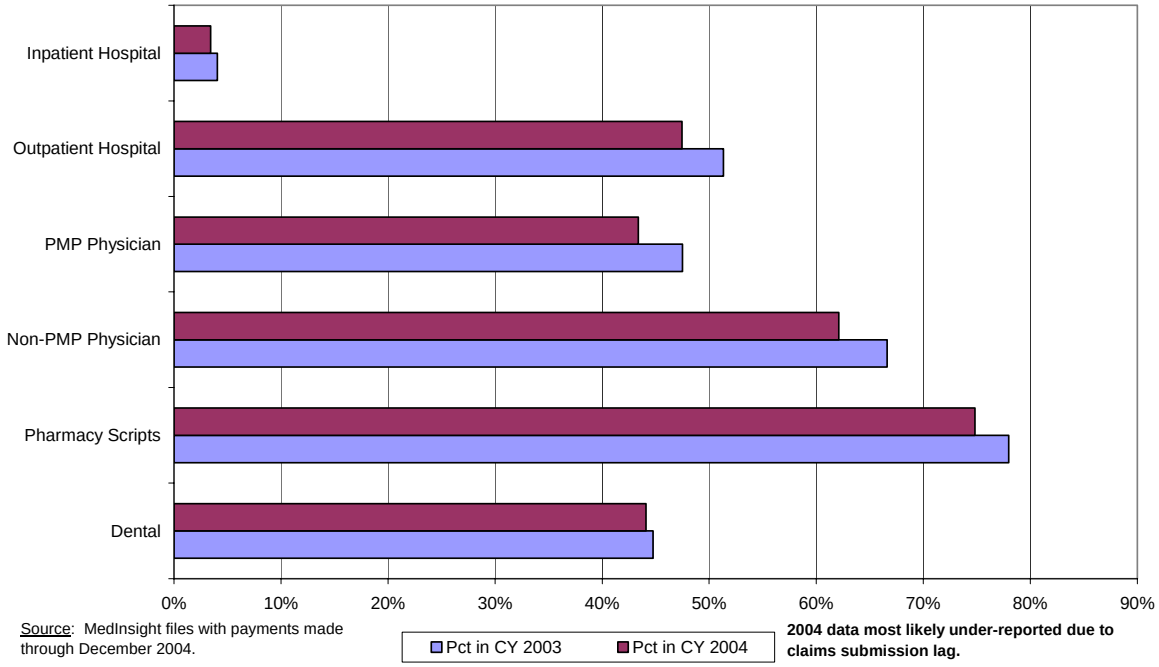
Exhibit III.4
Percent of CHIP Enrollees (Phases I and II) that Used Services
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with payments made through December 2004.

2004 data most likely under-reported due to claims submission lag.

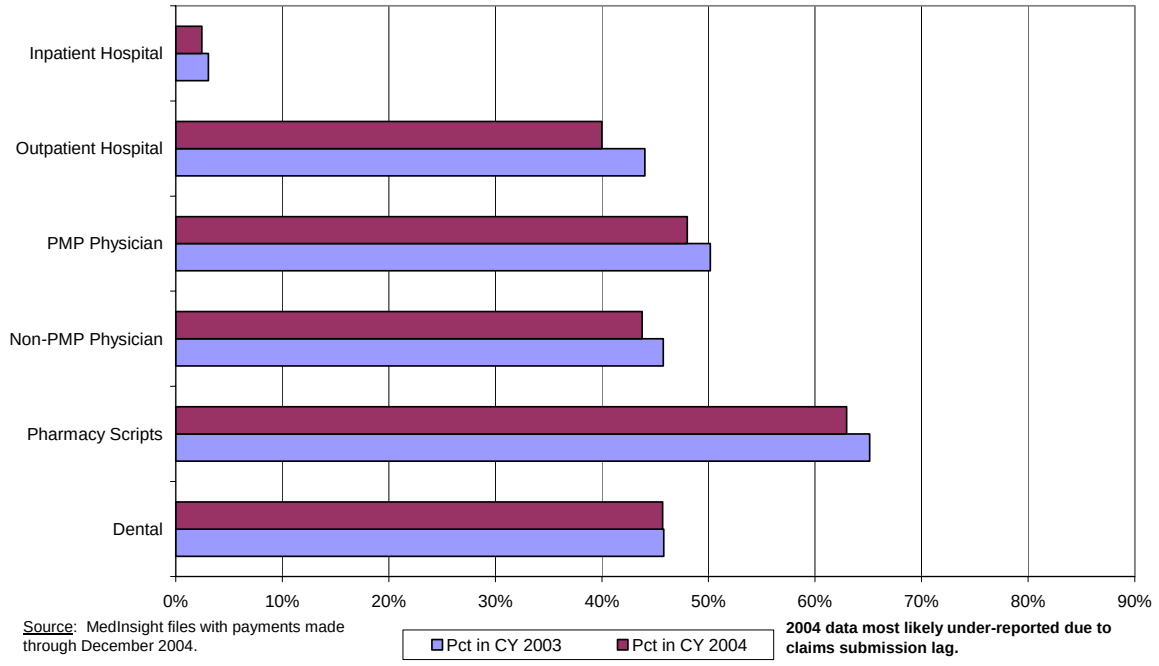
Exhibit III.5
Percent of Medicaid Enrollees that Used Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: MedInsight files with payments made through December 2004.

2004 data most likely under-reported due to claims submission lag.

Exhibit III.6
Percent of Medicaid Enrollees that Used Services
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with payments made through December 2004.

2004 data most likely under-reported due to claims submission lag.

How does utilization of PMP services differ among age groups?

Although it was found in Exhibits III.3 and III.4 that utilization of PMP services was around 50% of all enrollees, the utilization rates for this service may vary quite a bit based on age groups. This is because younger children are more likely to see their PMP more often than older children, if for no other reason than because certain immunizations are recommended for young children before age two.

The charts in Exhibits III.7-III.10 compare the utilization of PMP services by age group across multiple populations:

- Exhibits III.7 and III.8 compare CHIP member utilization (CHIP Phase I and CHIP Phase II combined) between those enrolled in PCCM/FFS delivery systems (III.7) and the RBMC delivery system (III.8).

- Exhibits III.9 and III.10 compare the same statistics for Medicaid children in PCCM/FFS and RBMC

Key findings from these exhibits show that:

- The percentage of children utilizing PMP services by age group is usually slightly higher (about five percentage points) in the RBMC delivery system than in the PCCM/FFS delivery systems.

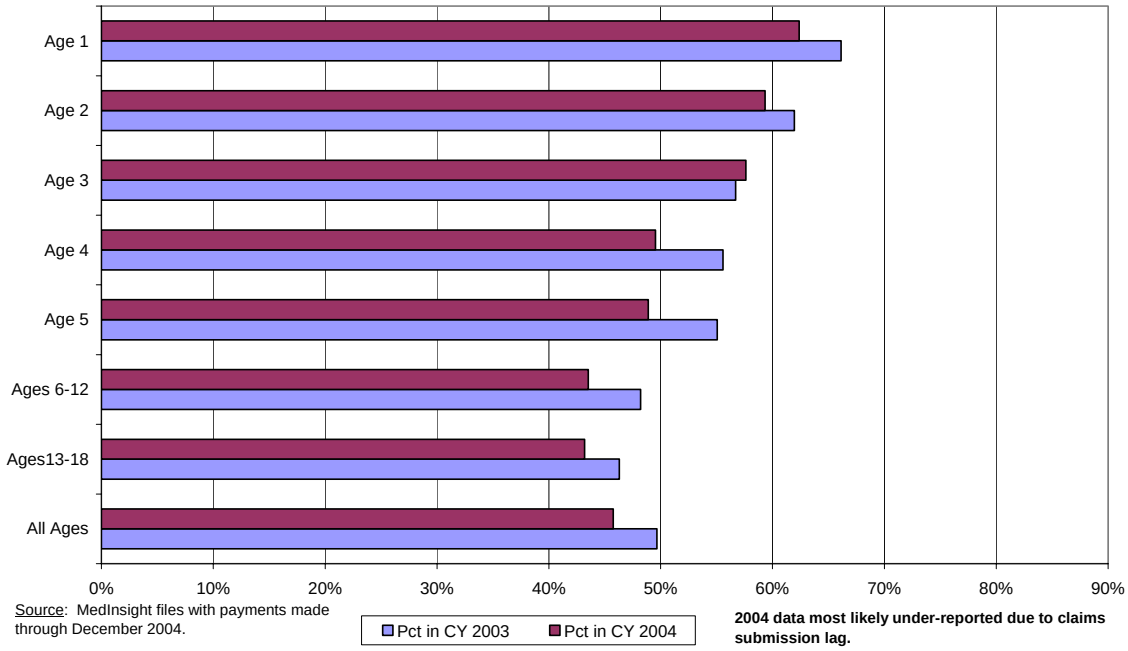
- The percentage of children that use PMP services is highest for one-year olds (65%-70%) and declines as the children get older, with the lowest group being the teenagers (45%-50% utilization).

- Whether or not access to PMP services increased from CY 2003 to CY 2004 cannot be verified, because it is likely that not all claims from CY 2004 have been submitted.

- In nearly all age groups and for both delivery systems, the percentage of children that use PMP services is higher in the CHIP program than it is in the Medicaid program.

There may be a reason why PMP utilization is lower than expected on these exhibits, and that is due to the definition of a PMP. For this analysis, a PMP is defined as a physician with one of five specialties (General Practitioners, General Pediatricians, Family Practitioners, OB/GYNs, and General Internists). Other physician specialties may see children for well-care visits, but these visits are not identified here because they are not defined as a PMP. Exhibits III.11-III.14 beginning on page III-13 explore this issue.

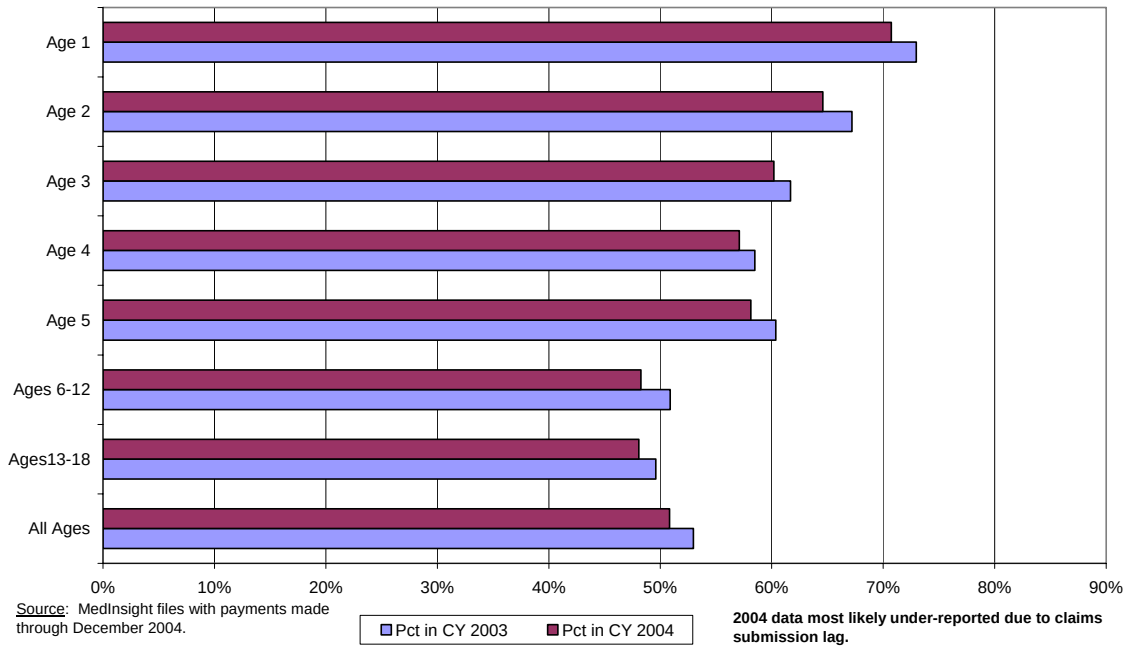
Exhibit III.7
Percent of CHIP Enrollees (Phases I and II) that Used PMP Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: MedInsight files with payments made through December 2004.

2004 data most likely under-reported due to claims submission lag.

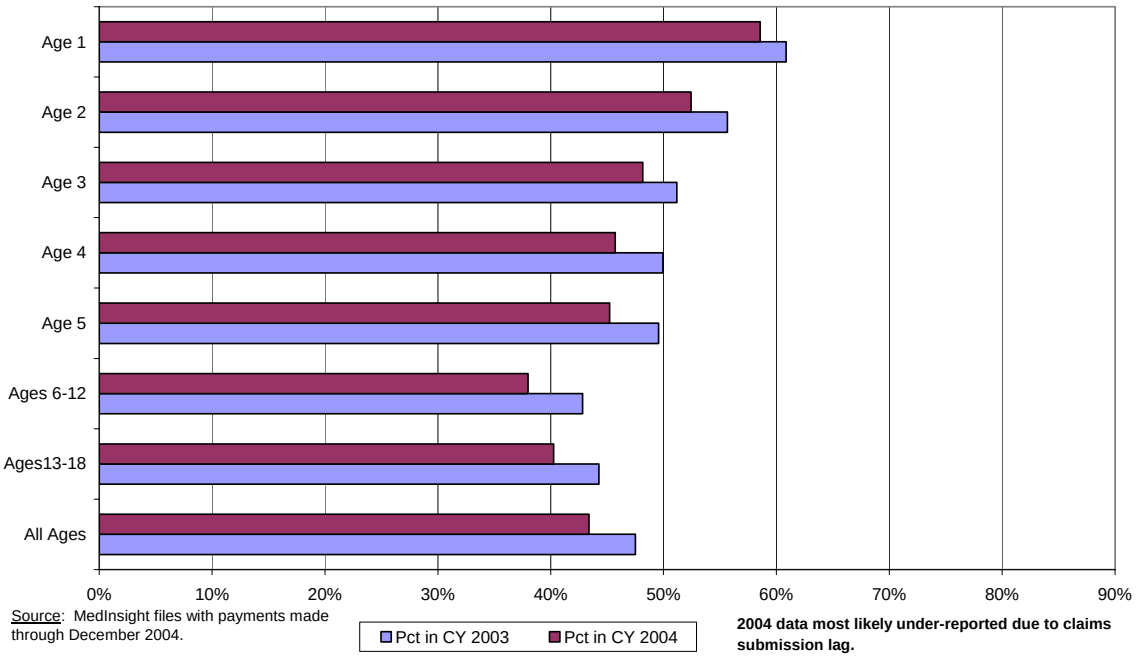
Exhibit III.8
Percent of CHIP Enrollees (Phases I and II) that Used PMP Services
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with payments made through December 2004.

2004 data most likely under-reported due to claims submission lag.

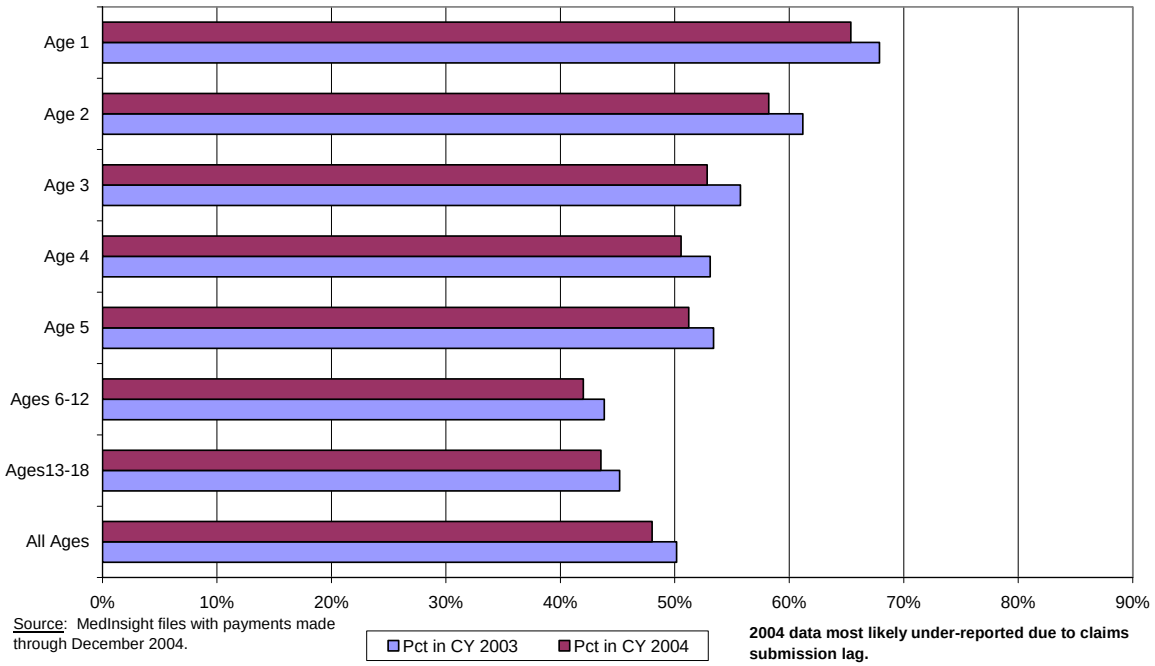
Exhibit III.9
Percent of Medicaid Enrollees that Used PMP Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: MedInsight files with payments made through December 2004.

2004 data most likely under-reported due to claims submission lag.

Exhibit III.10
Percent of Medicaid Enrollees that Used PMP Services
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with payments made through December 2004.

2004 data most likely under-reported due to claims submission lag.

How do access rates of PMP services change when non-PMP services are included?

The exhibits on the previous two pages show that only about 50% of children (all ages combined) enrolled in CHIP use PMP services. A PMP is the most likely provider of preventative care, so the fact that only half of the children use PMP services is a concern. However, many children might be receiving preventative care treatment from a non-PMP provider. Non-PMP providers are primarily specialists, but may also be performing some preventative care services. Physicians who practice in clinics or public health agencies are also classified as non-PMP, even though they may provide many preventative care services.

As a proxy for children's access to preventative care, the percentage of children who have visited any type of physician, PMP or non-PMP, was computed. The results for CY 2003 and CY 2004 for the PCCM/FFS and RBMC delivery systems are shown in Exhibits III.11-III.14 on the following two pages. These exhibits show the following for each age group:

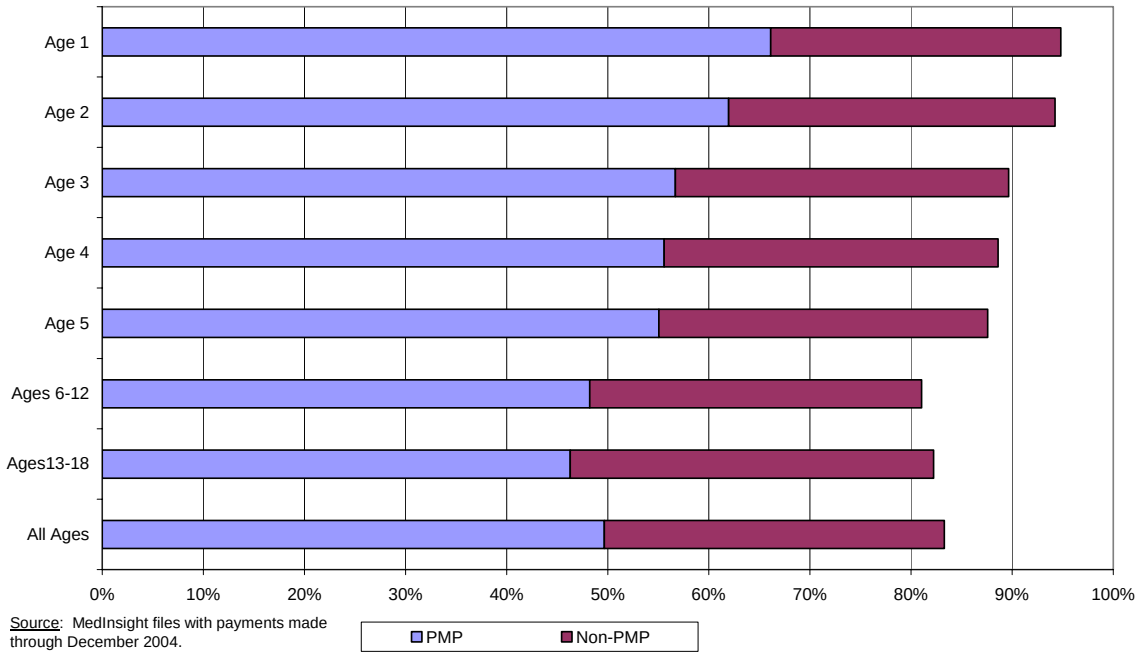
- The blue portion of the bar shows the percentage of children that had a PMP visit in the calendar year (repeated from Exhibits III.7-III.10)
- The red portion of the bar shows the percentage of children who did not have a PMP visit in the year (as PMP is defined) but did have a non-PMP visit (defined as a visit to a clinic, public health agency, or to a physician not defined as a PMP)
- The sum of the two bars shows the total percentage of children by age group that had either a PMP or a non-PMP visit.

Exhibits III.11-III.14 focus solely on the CHIP population. Exhibits III.11 and III.12 compare utilization of members between CY 2003 and CY 2004 for the PCCM/FFS delivery systems. Exhibits III.13 and III.14 compare the same years for the RBMC population. The findings shown on these exhibits, when comparing CY 2003 to CY 2004, are similar. The percentage of users in CY 2003 is slightly higher than that shown for CY 2004, but this could be because not all of the utilization data has yet been submitted for CY 2004.

The inclusion of the non-PMP data, however, improves the percentage of children utilizing physician services dramatically. Whereas only 50% of children had visited their PMP in each calendar year, about 80% had seen either a PMP or a non-PMP in this time period. For children age one, this percentage rises to around 90%.

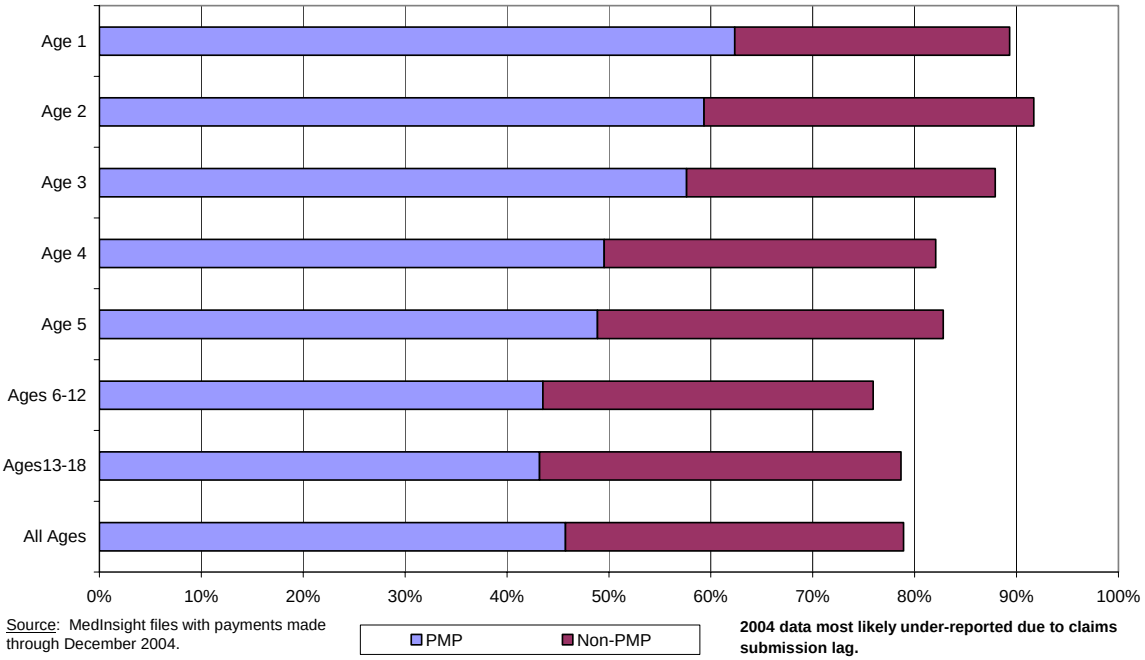
When comparing the types of providers children see, a larger percentage of CHIP children in RBMC visited a PMP than children in the PCCM or FFS systems had. But when non-PMP visits are included in the analysis, the PCCM and FFS children have a greater overall percentage of visits (PMP and non-PMP together) than RBMC children.

Exhibit III.11
Percent of CHIP Enrollees that Used PMP or Non-PMP Services in CY 2003
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: MedInsight files with payments made through December 2004.

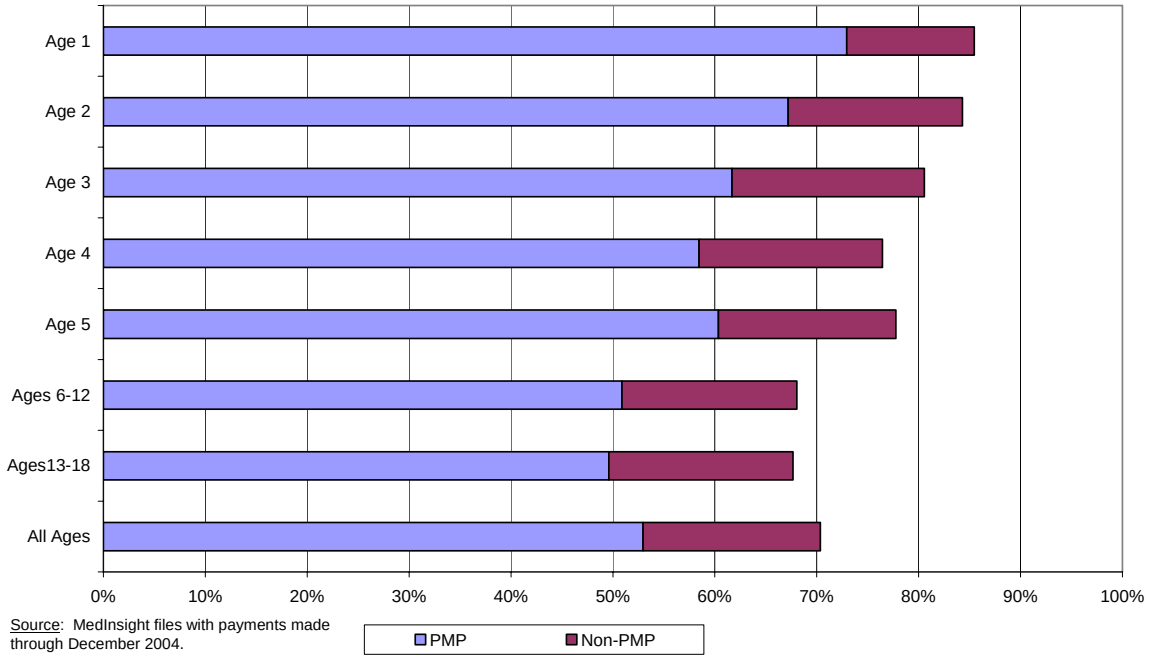
Exhibit III.12
Percent of CHIP Enrollees that Used PMP or Non-PMP Services in CY 2004
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: MedInsight files with payments made through December 2004.

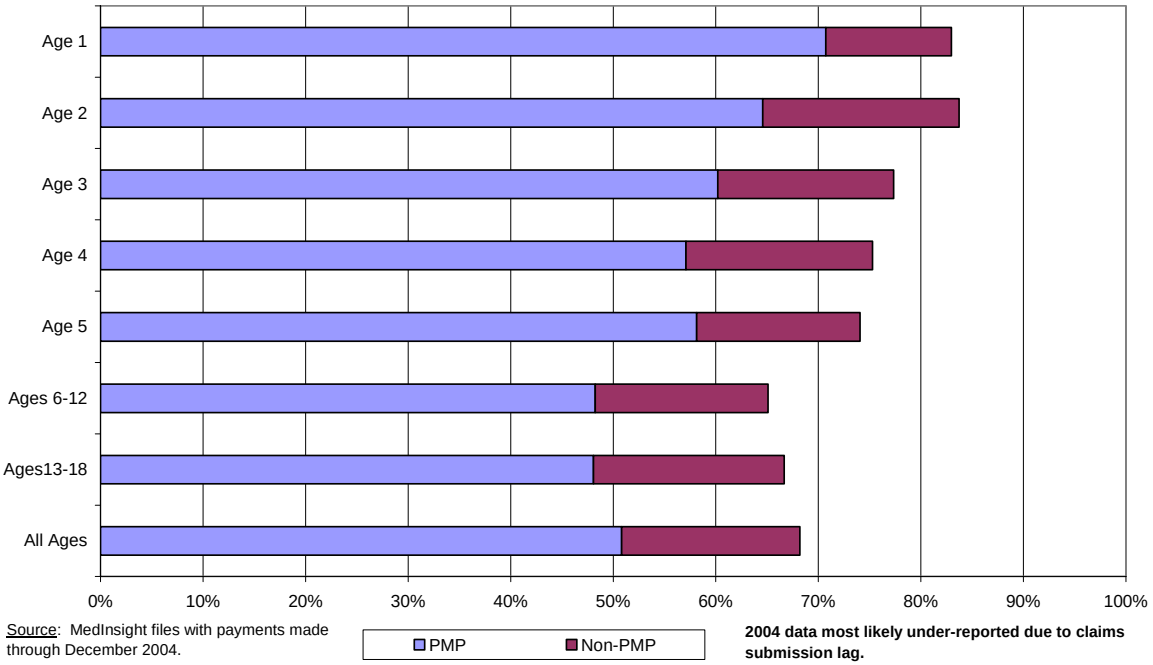
2004 data most likely under-reported due to claims submission lag.

Exhibit III.13
Percent of CHIP Enrollees that Used PMP or Non-PMP Services in CY 2003
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with payments made through December 2004.

Exhibit III.14
Percent of CHIP Enrollees that Used PMP or Non-PMP Services in CY 2004
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with payments made through December 2004.

2004 data most likely under-reported due to claims submission lag.

CHAPTER IV
SERVICE UTILIZATION AND EXPENDITURE TRENDS

INTRODUCTION

Chapter IV provides an analysis of trends in both the utilization of services available to CHIP children as well as a comparison of the total expenditures paid by the state for children in CHIP and children of the same age in Medicaid. Because the size of the two populations is quite different, a common measurement used is the per member per month (PMPM) expenditure comparison. Differences in the PMPM expenditures can be driven by multiple factors, and these are all reviewed in this chapter, including:

- Determine if there are differences in PMPM expenditures between CHIP Phase I, CHIP Phase II and Medicaid children and, if so, if these are due to different utilization patterns, higher/lower costs of services, or both between the two populations

- If differences in utilization patterns are found, identify if there are any differences among the Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC) and Fee-for-Service (FFS) delivery systems.

- If differences in the PMPM expenditures are found, identify if some or all are attributable to differences in the expenditure patterns among age groups. Past evaluations conducted by EP&P Consulting (EP&P) found that the composition of the ages within a program (e.g. more teenagers in CHIP Phase I, more infants in Medicaid) often drove differences in both utilization and payment.

After a section that identifies major findings in utilization and expenditures found on the next page, the remainder of the chapter presents findings of utilization and expenditure trends across major service groups such as:

- PMPM expenditure trends for all services combined
- Hospital services (including inpatient and outpatient hospital)
- Physician services (including Primary Medical Providers and specialists)
- Pharmacy scripts
- Dental services
- Other services paid primarily in the PCCM and FFS delivery systems

To capture utilization trends for specific time periods, EP&P evaluated utilization and expenditures based upon the date when the service was received, not when the service was paid for by the state. As a result, not all claims for the latter half of calendar year 2004 are represented because providers are still submitting claims for payment. This is especially true for hospital claims. Therefore, utilization and payment charts that identify data from 2004 only

reflect information through the month of October 2004 so that the findings are not artificially skewed.

Another item that EP&P has found each year we have conducted the CHIP evaluation is that comparisons between CHIP and Medicaid children is always skewed because almost all of the children under age one are in the Medicaid portion of Hoosier Healthwise and not in CHIP. As these children are higher utilizers of services than other children, the findings for Medicaid children could not be compared fairly to findings for CHIP children. Therefore, in this year's report, all data presented in this chapter excludes information for children enrolled when they were under age one (for both the CHIP and Medicaid portions of the program). By doing this, any differences in utilization or payments for CHIP and Medicaid children would more likely be due to something other than the age groups each program serves.

KEY HIGHLIGHTS

- CHIP expenditures per member per month are lower than expenditures per member per month for Medicaid children. This is true for children enrolled in both the PCCM/FFS delivery systems as well as those enrolled in the RBMC delivery system. For primary services (general hospital, physician, and pharmacy), CHIP children cost the State about 5% less on average per month than Medicaid children. When other services (including mental health-related services) are included in the comparison, CHIP children cost the State significantly less—about 20% less—on average each month than Medicaid children

- For services provided in both the PCCM/FFS and the RBMC delivery systems, CHIP expenditures per member per month for the RBMC delivery system ($72 PMPM) are $9 less than per member per month expenditures for the same services delivered to the PCCM and FFS populations ($81 PMPM).

- The distribution of expenditures across categories of service for the PCCM and FFS populations in CHIP has not changed significantly between SFY 2003 and SFY 2004. Pharmacy expenditures have increased at a higher pace than other service categories.

- Indiana has a similar distribution of CHIP expenditures among major services (hospital, physician, pharmacy, and dental) as compared to other states in its region.

- When measured on a claims per 1,000 enrollees level, children in the RBMC delivery system of CHIP have higher utilization rates for primary medical visits and dental services than children in PCCM and FFS delivery systems, but lower rates of utilization for hospital and pharmacy services.

- In CY 2004, per member per month expenditures for CHIP Phase I children were over $30 higher than those for CHIP Phase II children.

- CHIP Phase II children have utilization rates that are either similar to CHIP Phase I children or below CHIP Phase I for all service categories. These differences in utilization explain at least some of the difference in PMPM expenditures between the programs.

- Except for hospital services (where the age groups are relatively equal), teenagers are responsible for higher average claim costs than younger children.

- The most expensive service for both CHIP Phase I and CHIP Phase II children (measured on a per member per month basis) is pharmacy services. The same is true for children in Medicaid, although mental health services are almost as high for Medicaid children, whereas they represent less than 10% of total service payments in the CHIP budget.

ANALYSES RELATED TO TOTAL SERVICE UTILIZATION AND EXPENDITURES

How do expenditures for CHIP children compare to Medicaid children?

Prior annual evaluation reports found that differences in expenditures for services between CHIP and Medicaid were usually based on different utilization patterns of members. For example, CHIP Phase I has experienced a higher percentage of total expenditures in pharmacy scripts due to the higher concentration of teenagers who were also found to have more expensive scripts on a per claim basis than younger children.

Expenditure patterns were reviewed for federal fiscal years (FFY)[1] 2003 and 2004 in the PCCM and FFS delivery systems. Data from the RBMC delivery system is not included because payments in the RBMC delivery system are made on a monthly basis for each member for all services combined, not by service category. The total expenditures were compared for both years within each program (CHIP Phase I, CHIP Phase II, and Medicaid) to determine if there have been shifts in expenditures between the services over the years. The percentage payments for each service type relative to total payments were also compared across the programs to see if one program spends more on a particular service than another program.

Between CHIP Phase I and CHIP Phase II, the distribution of expenditures between the different service categories is comparable. Outpatient hospital, non-PMP and dental services account for a slightly higher percentage of total expenditures in CHIP Phase II than they do in CHIP Phase I, while mental health and other services account for a lower percentage of total expenditures in CHIP Phase II. The fact that the coverage of mental health services is more limited in CHIP Phase II is driving this result. Other findings, as shown in Exhibit IV.1, include:

[1] To better compare total expenditures between years and programs, the federal fiscal year (October to September) was used because much of the expenditures at the end of CY 2004 have not been reported yet.

- Expenditures for pharmacy scripts and dental services together account for about half of total expenditures for both the CHIP Phase I and Phase II programs.

- The dental services category was the largest expenditure category for CHIP Phase II in both years at 27.5% of total expenditures. This has held true since CHIP Phase II started.

- The difference in the percentage distribution of expenditures between the CHIP and Medicaid programs is due to the higher payments for mental health services in Medicaid. Though mental health services is the third largest expenditure category in Medicaid, it accounts for less than 10% of expenditures in CHIP Phase I and even less in CHIP Phase II.

From FFY 2003 to 2004, total expenditures for PCCM and FFS (that is, those outside of the RBMC system) grew 3.8% in CHIP Phase I and grew 15.1% in CHIP Phase II, but Medicaid payments decreased 5.7%. The change in Medicaid is mostly the result of a migration of members from the PCCM delivery system into the RBMC delivery system. The CHIP Phase II program still saw a healthy increase in expenditures since the program grew 13% in enrollment overall during the time period and there was a net gain of members in the PCCM portion of CHIP Phase II.

Exhibit IV.1
Total PCCM and FFS Expenditures
For Federal Fiscal Years 2003 and 2004
By Program and Service Category

	CHIP PHASE I PROGRAM			
	FFY 2003		FFY 2004	
Category of Service	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total
Inpatient Hospital	$3,792,444	9.0%	$3,831,740	8.8%
Outpatient Hospital	$3,726,791	8.9%	$3,630,562	8.3%
PMP Physician	$1,786,785	4.3%	$1,638,280	3.8%
Non-PMP Physician	$4,219,953	10.0%	$4,261,336	9.8%
Pharmacy Scripts	$9,521,478	22.7%	$10,807,014	24.7%
Dental	$9,759,861	23.2%	$9,773,794	22.4%
Mental Health	$4,072,153	9.7%	$4,165,522	9.5%
Other Cap Services	$3,211,889	7.6%	$3,413,294	7.8%
Other Non-Cap Services	$1,901,074	4.5%	$2,146,600	4.9%
Total	**$41,992,428**	**100.0%**	**$43,668,142**	**100.0%**

	CHIP PHASE II PROGRAM			
	FFY 2003		FFY 2004	
Category of Service	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total
Inpatient Hospital	$982,143	9.9%	$935,880	8.2%
Outpatient Hospital	$1,160,870	11.7%	$1,260,663	11.0%
PMP Physician	$572,738	5.8%	$580,328	5.1%
Non-PMP Physician	$1,336,870	13.4%	$1,438,923	12.5%
Pharmacy Scripts	$1,994,572	20.1%	$2,775,621	24.2%
Dental	$2,730,483	27.5%	$3,156,536	27.5%
Mental Health	$377,370	3.8%	$396,294	3.5%
Other Cap Services	$743,243	7.5%	$884,687	7.7%
Other Non-Cap Services	$42,179	0.4%	$39,103	0.3%
Total	**$9,940,468**	**100.0%**	**$11,468,035**	**100.0%**

	MEDICAID PROGRAM			
	FFY 2003		FFY 2004	
Category of Service	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total
Inpatient Hospital	$45,698,181	11.6%	$36,038,906	9.7%
Outpatient Hospital	$30,571,567	7.8%	$27,852,139	7.5%
PMP Physician	$16,267,650	4.1%	$14,084,726	3.8%
Non-PMP Physician	$34,859,390	8.9%	$31,305,323	8.4%
Pharmacy Scripts	$69,984,456	17.8%	$70,225,893	18.9%
Dental	$67,895,584	17.3%	$67,473,800	18.2%
Mental Health	$63,610,286	16.2%	$63,665,903	17.2%
Other Cap Services	$30,878,219	7.9%	$27,304,664	7.4%
Other Non-Cap Services	$32,835,048	8.4%	$32,689,314	8.8%
Total	**$392,600,381**	**100.0%**	**$370,640,668**	**100.0%**

Notes
1. Capitation payments made to managed care entities are not included in the above totals.
2. The totals for the Medicaid group represent expenditures for the children in Medicaid only.
3. Cap services are those also covered in RBMC. Non-cap services are those not covered in RBMC.
4. All expenditures are categorized by fiscal year based upon dates of service.

Source: MedInsight files with payments made through December 2004

How do Indiana's expenditures for children compare to those of other states?

To determine how Indiana's expenditures compare to its peers, the distribution of expenditures by service category was compared to other states' information. The states compared to Indiana are its border states and those in its CMS region—namely Illinois, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin. The data for comparison consisted of information that states are required to report to CMS on the CMS 21 form for CHIP programs. Data from FFY 2002, the most recent year available, was used for this comparison.

Since states vary widely on how they implemented their CHIP programs (some are Medicaid expansions, some are Title XXI programs, and some are a combination of both), expenditures for all CHIP program types in a state were combined. Capitation payments to managed care organizations were also excluded, and since Minnesota's CHIP program is all covered under managed care, Minnesota was also excluded from this comparison.

The comparison across states showed that:

- Indiana ranks in the middle of the comparison states in terms of expenditures for inpatient services, outpatient services, physician services and dental services.

- Indiana has the second highest percentage of expenditures for prescribed drugs (behind Wisconsin) and for other services (behind Illinois). Major items included in "other services" are those for mental health, laboratory, and therapy services.

Exhibit IV.2
Distribution of CHIP Expenditures by Service Category in FFY 2002
Based on Eligibles in Non-Managed Care Delivery Systems

	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Prescribed Drugs	Dental Services	Other Services
Indiana	11%	10%	11%	20%	8%	31%
Illinois	10%	8%	8%	17%	15%	36%
Kentucky	7%	15%	15%	19%	9%	31%
Michigan	16%	6%	10%	13%	13%	24%
Ohio	18%	13%	12%	19%	5%	29%
Wisconsin	16%	9%	3%	22%	7%	26%

Source: CMS-21 Data for Federal Fiscal Year 2002, CMS Website

How do expenditures compare between the RBMC delivery system and the PCCM/FFS delivery systems for children in CHIP and Medicaid when children under age one are excluded?

The RBMC delivery system was implemented in Hoosier Healthwise to:

- Provide a medical home for Hoosier Healthwise members so that better and more coordinated care can be provided
- Improve the quality of services provided
- Gain cost efficiencies by obtaining services from providers in a cost effective manner

The monthly capitation payments made to managed care organizations (MCOs) that perform the service functions for children in the RBMC delivery system were compared to the payments made on a claim-by-claim basis to providers who perform services for children in the PCCM and FFS delivery systems. This is especially important to study since the state is continuing to encourage, and in some counties require, enrollment in the RBMC delivery system.

The payment and expenditure analyses presented in Exhibits IV.3 through IV.5 do not include dental service expenditures. This is because dental services are "carved out" of the RBMC delivery system, meaning that the MCOs are not responsible for providing these services and therefore their payment does not include the cost to provide the service.

Exhibit IV.3 shows the per member per month (PMPM) payments made to MCOs compared to the PMPM payments made in the PCCM and FFS delivery systems during federal fiscal year 2004. As in Exhibit IV.1, the federal fiscal year was used to avoid understating total payments by including months with missing data at the end of calendar year 2004. PMPM figures are used for comparison purposes, even though the method of payment is different depending on the type of delivery system. For RBMC, the PMPM payments are calculated by dividing the total capitation payments in the year by the member months of RBMC members covered. For PCCM and FFS, the PMPM payments are calculated by dividing the total amount paid on claims in the year by the member months of total PCCM and FFS members, regardless of whether or not all members used the service. It should be noted that, in order to fairly compare the PMPMs, only services covered by MCOs were included in the PMPM for the PCCM and FFS populations.

The key findings from Exhibit IV.3 shown on the next page are that:

- Medicaid children age one through eighteen have higher PMPM payments than CHIP children for both the RBMC delivery system and the combination of the PCCM and FFS delivery systems.
- The RBMC delivery system saves the state about $10 in PMPM payments for services for both the CHIP children and the Medicaid children.

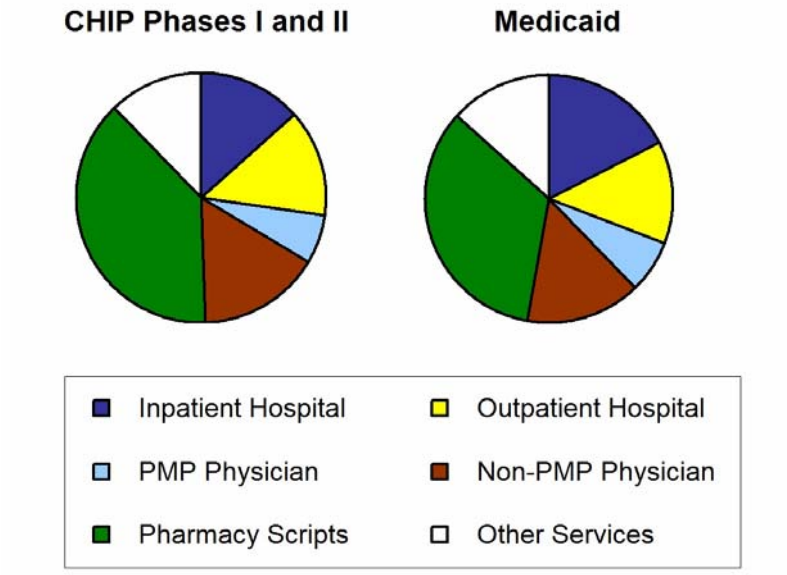
Exhibit IV.3
Payment Comparison Across Hoosier Healthwise Delivery Systems
For Federal Fiscal Year 2004 (October 2003-September 2004)

	CHIP Phases I and II	Medicaid
RBMC PMPM Payments	$71.81	$75.39
PCCM and FFS PMPM Payments	$81.05	$86.55

Source: MedInsight

The first finding above suggests that Medicaid children are either utilizing a different mix of services than CHIP children are or they are utilizing more services than CHIP children. Exhibit IV.4 compares the distribution of expenditures on all services for CHIP children compared to Medicaid children. For PCCM and FFS, the difference in the PMPM between CHIP and Medicaid is primarily due to inpatient hospital services (75% of the difference between CHIP and Medicaid is due to this). A more limited benefit package in CHIP Phase II than in Medicaid, such as for mental health services, accounts for the remainder.

Exhibit IV.4
Distribution of Expenditures by Service Category for CHIP and Medicaid



Source: MedInsight files through December 2004

The second finding from Exhibit IV.3 suggests that there are cost savings by moving children to the RBMC delivery system. RBMC saves the state approximately $10 per member per month for service expenditures in all three programs being analyzed.

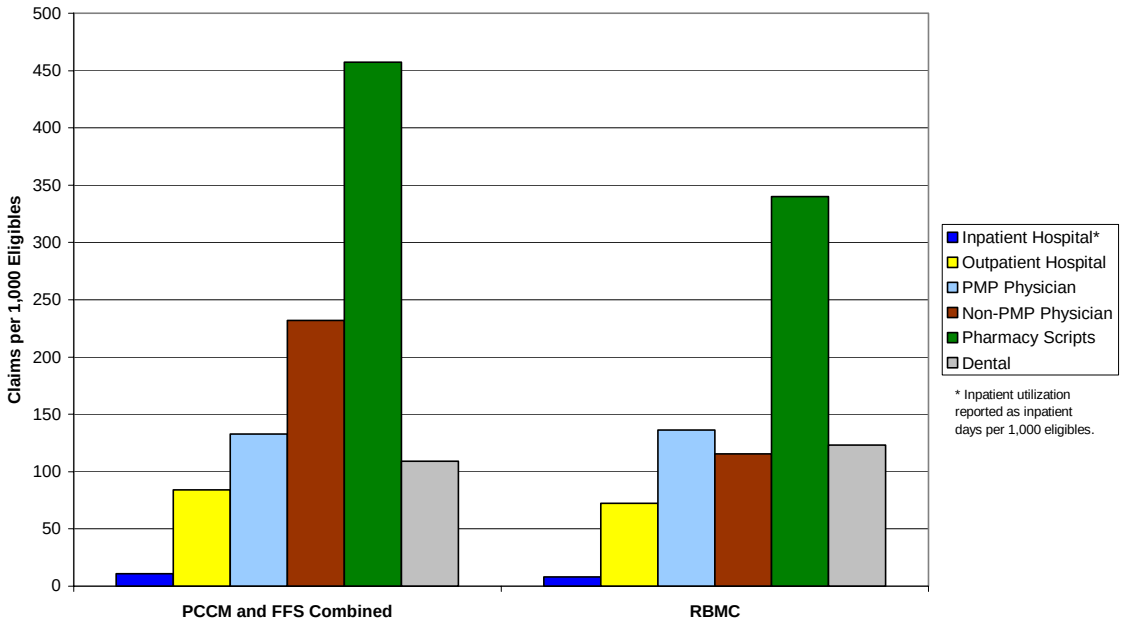
Is the reason that CHIP children in the RBMC delivery system are less costly than CHIP children in the PCCM/FFS delivery systems because children in the RBMC systems are receiving fewer services?

The data from Exhibit IV.5 suggest that the one area where utilization is different between the PCCM/FFS and RBMC delivery systems is in pharmacy scripts. The data show that the RBMC delivery system has less than 350 scripts per 1,000 CHIP members while the PCCM/FFS combined delivery systems has over 450 scripts per 1,000. MCOs in the RBMC delivery system have the opportunity to develop their own formularies (the listing of drugs that members can receive). This, in conjunction with medical management, is believed to account for lower utilization of pharmacy in the RBMC system.

Other service areas are relatively comparable between children enrolled in the PCCM/FFS delivery systems and the RBMC delivery system. One other difference cited is for "non-PMP" services. These relate to services billed by providers whose focus is not related to primary care or well-child visits. A significant portion of claims in this category relate to mental health services, which are not paid for as part of the monthly capitation payment in the RBMC delivery system and thus are not represented in the RBMC category.

It should be noted that dental services are also not covered in the monthly RBMC capitation payment, but utilization between PCCM/FFS and RBMC CHIP children is shown for comparison purposes.

Exhibit IV.5
Claims per 1,000 Eligibles by Delivery System
Federal Fiscal Year 2004 (October 2003-September 2004)



Source: MedInsight files through December 2004

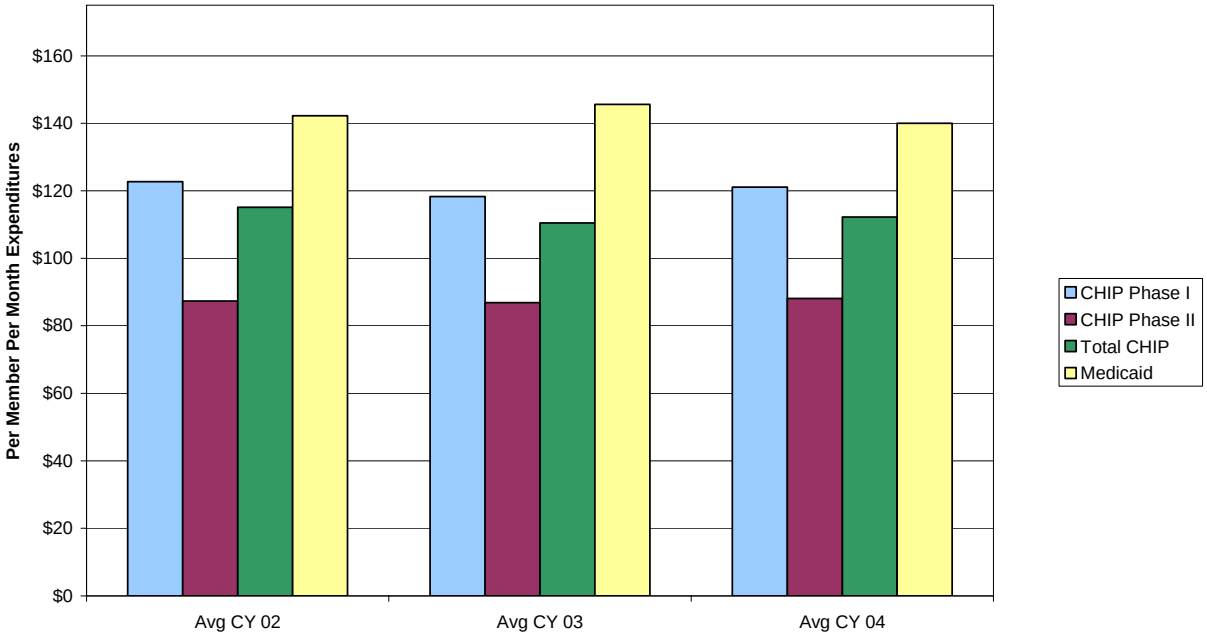
How do the overall per member per month expenditures differ between CHIP Phase I and CHIP Phase II?

Both CHIP Phase I PMPM expenditures and CHIP Phase II PMPM expenditures have grown slightly over the past three years (see Exhibit IV.6). CHIP Phase I had significantly higher PMPM expenditures (about $120) than Phase II of the CHIP Program (about $85), but PMPM expenditures for either CHIP program were still lower than those for the Medicaid program (about $140).

Most of the differences in PMPMs, however, are driven by utilization of specific services and the more limited coverage of some services in CHIP Phase II. Differences between CHIP Phase I and CHIP Phase II are primarily driven by the fact that over-the-counter pharmacy is not covered in CHIP Phase II but is covered in CHIP Phase II. Likewise, the mental health benefit is more limited in CHIP Phase II.

Differences in the PMPM between Total CHIP and Medicaid are driven by higher utilization (and thus, expenditures) of inpatient psychiatric hospital and outpatient mental health services among Medicaid children. When these two services are removed, the average PMPM for Medicaid children is about $87 versus $81 for Total CHIP.

Exhibit IV.6
Per Member Per Month Expenditures (All Services)
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004



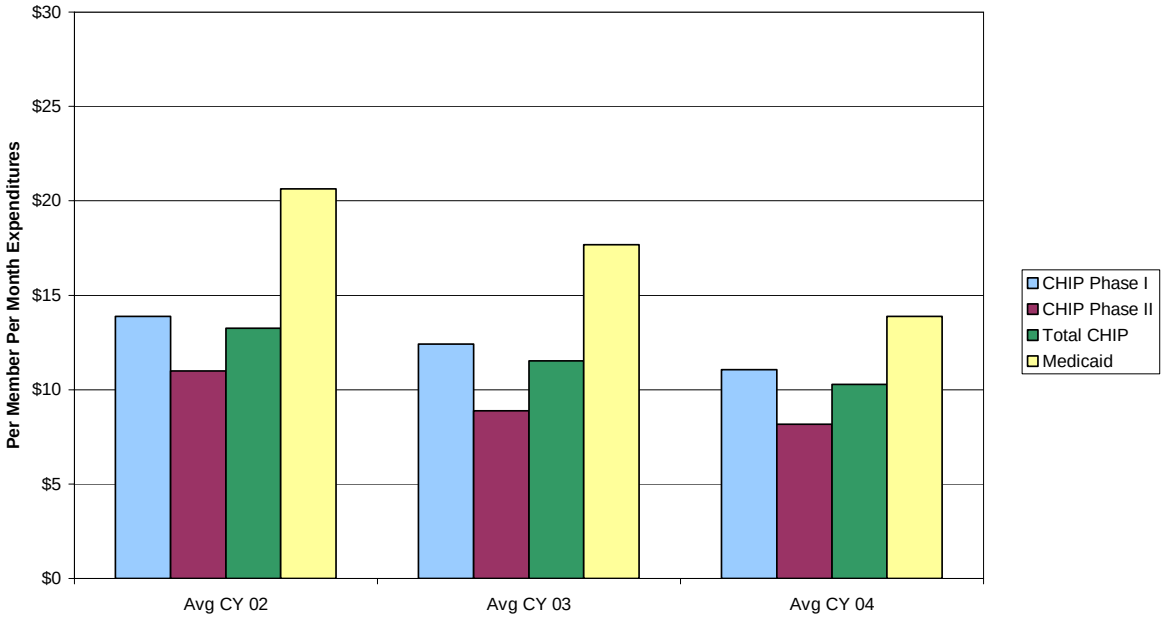
Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

HOSPITAL SERVICES

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II and Medicaid for inpatient and outpatient hospital services? Do expenditures relate to utilization trends?

Across all three programs, PMPM expenditures for inpatient services in the PCCM/FFS delivery systems have declined over the past three years. Exhibit IV.7 below shows the average PMPM expenditures by program (CHIP Phase I, CHIP Phase II, Total CHIP and Medicaid children) in each of the past three years for children ages one through eighteen. Though there are probably some unprocessed claims not included in CY 2004, a decline across all programs from CY 2002 to CY 2003 is evident. PMPM expenditures for Medicaid are higher than those for either CHIP program, which is primarily caused by Medicaid's higher levels of utilization (see Exhibit IV.8 on the next page). The opposite is true for CHIP Phase II, for which the lowest utilization leads to the lowest PMPM expenditures.

Exhibit IV.7
Inpatient Hospital Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004

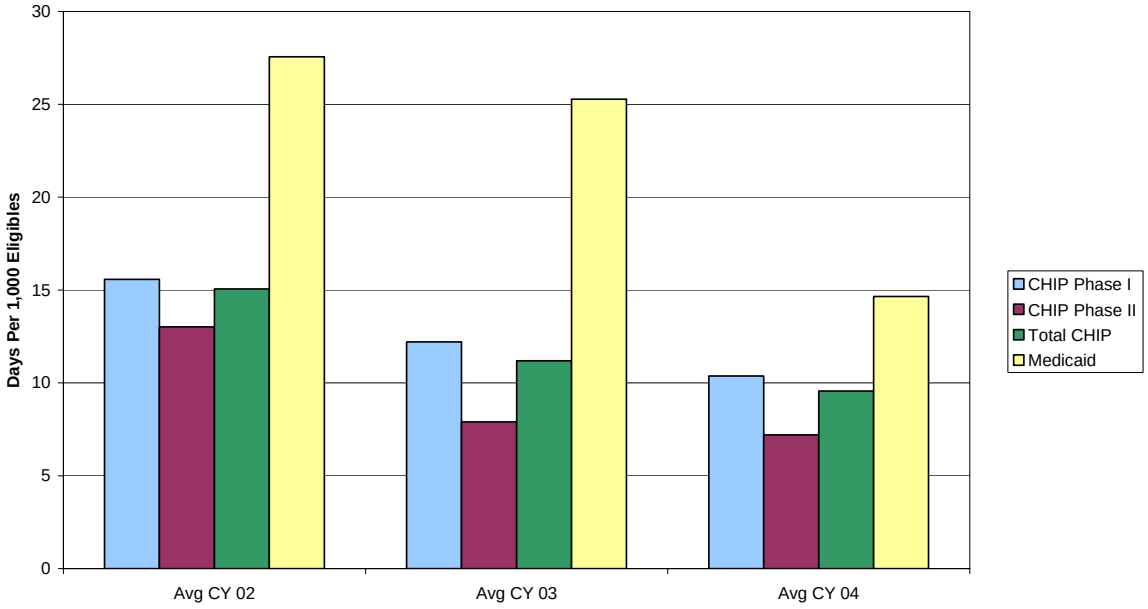


Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

Utilization of inpatient services is represented in Exhibit IV.8 and follows the same patterns as PMPM expenditures, suggesting a strong relationship between the two. Unlike the other services discussed in this chapter, utilization of inpatient services are evaluated using inpatient days per 1,000 eligibles rather than inpatient claims per 1,000, which often include multiple days on one claim. Also, unique to data for inpatient services is the relatively low volume of claims causing data for this service to be erratic. The large reduction in the days per 1,000

eligibles factor for calendar year may stem from two possible factors—missing claims yet to be submitted to the state by hospitals participating in PCCM/FFS, missing shadow claims from managed care organizations in RBMC, or both.

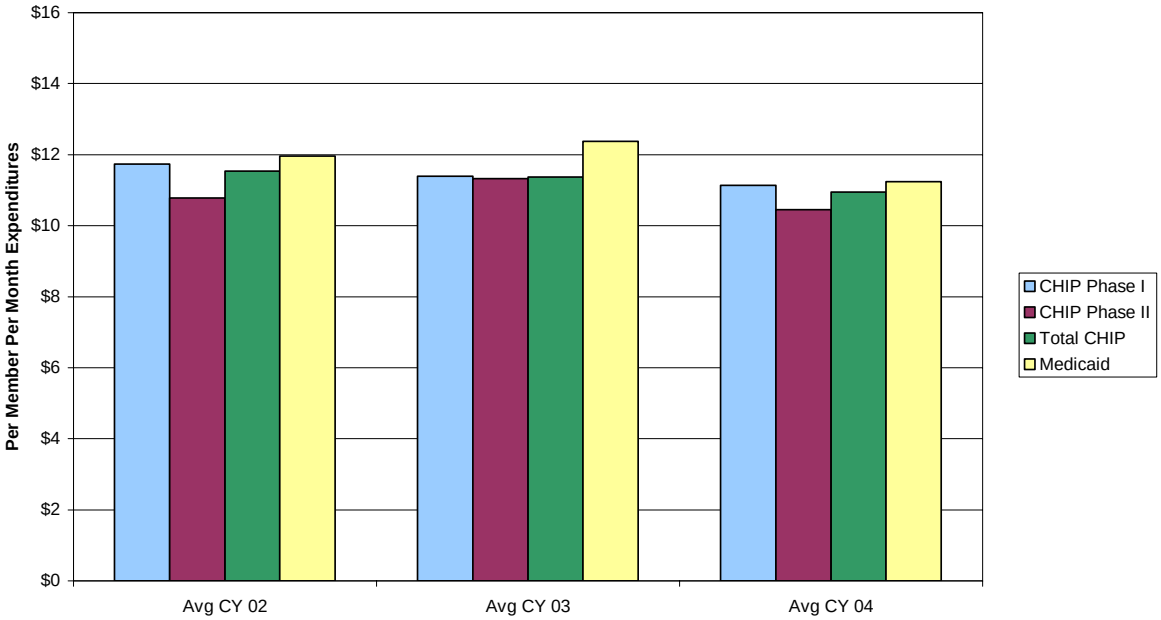
Exhibit IV.8
Inpatient Hospital Days Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004



Source: MedInsight files available through December 2004. Shadow claims (RBMC delivery system) included.

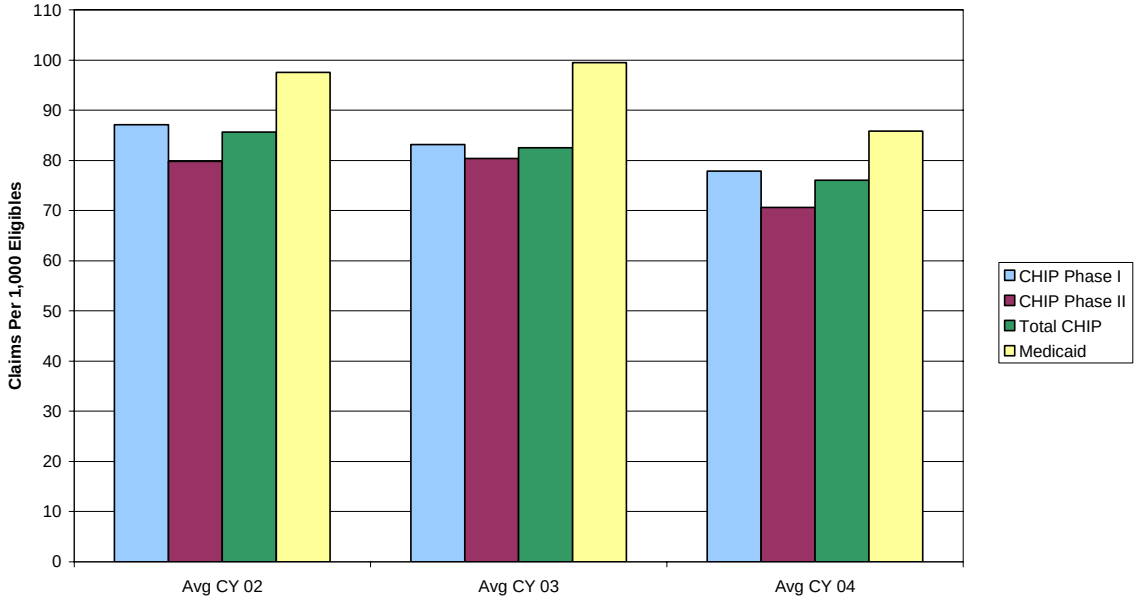
The volume of claims for outpatient services, on the other hand, is much larger, resulting in more stable results. Exhibit IV.9 on the next page shows that PMPM expenditures for outpatient services have been near $11 and $12 for three years, and there is little variation between CHIP and Medicaid in this regard. There are some differences, however, in utilization (Exhibit IV.10). For example, claims per 1,000 eligibles for CHIP Phase I are higher than those for CHIP Phase II across all three years, and utilization for Medicaid children is higher than CHIP children. Therefore, when utilization is higher for Medicaid but the PMPM value is close to the CHIP value, this means that the average payment for the actual services being delivered to Medicaid children must be lower than that for CHIP children. This implies that there may be some differences in the types of services CHIP and Medicaid children are receiving in the outpatient hospital setting.

Exhibit IV.9
Outpatient Hospital Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004



Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

Exhibit IV.10
Outpatient Hospital Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004

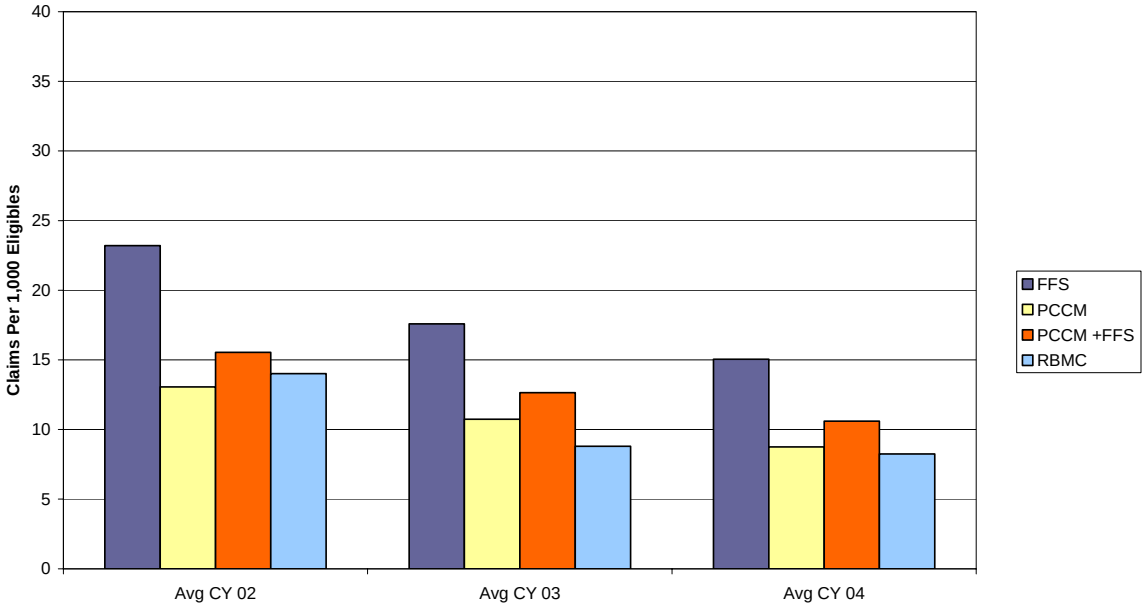


Source: MedInsight files available through December 2004. Shadow claims (RBMC delivery system) included.

How does the utilization of inpatient and outpatient hospital services for CHIP members compare across the three delivery systems?

As found in past annual reports, CHIP members in the FFS delivery system use inpatient services at a higher rate than either of the other two delivery systems. The fee-for-service "window" is the most likely cause for this result. When members first enter Hoosier Healthwise, they are often placed in FFS temporarily before finding a home in PCCM or RBMC. One common reason for this is that children often discover that they are eligible for CHIP after they have already been hospitalized. Therefore, it is likely that many members utilizing inpatient hospital services are new members, and hence are in the FFS delivery system. Having said that, utilization from FFS members seems to have declined in recent years. This may reflect the fact that more counties in Indiana now have mandatory RBMC enrollment, in which the fee-for-service "window" period is either smaller or nonexistent.

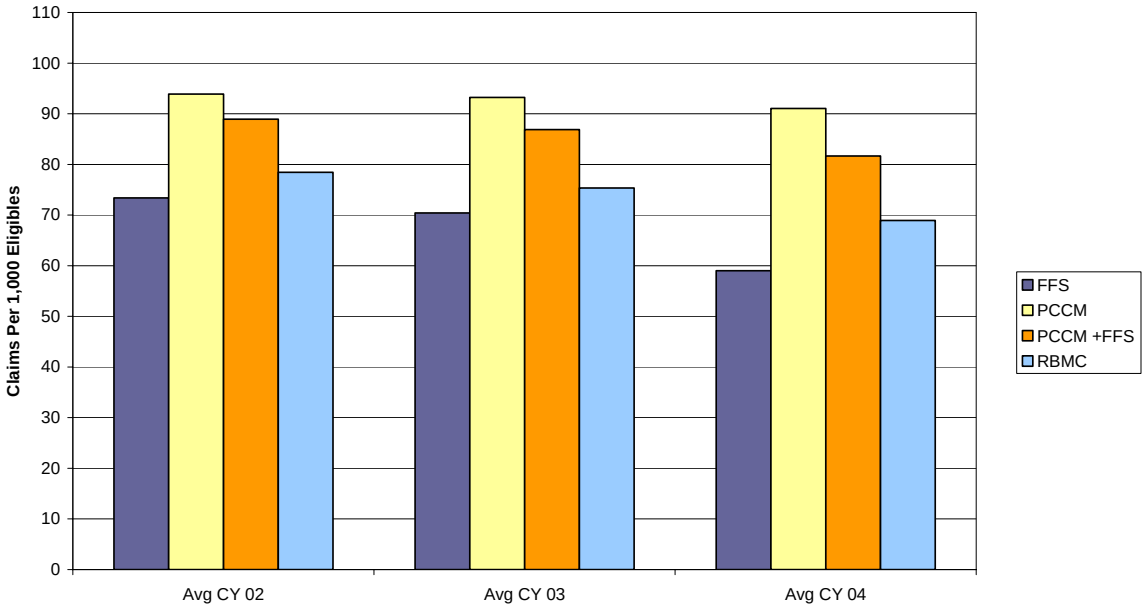
Exhibit IV.11
Inpatient Days Per 1,000 Eligibles
For All CHIP Members By Delivery System
January 2002 - October 2004



Source: MedInsight files available through December 2004.

High FFS utilization compared to other delivery systems is unique to inpatient services. Utilization from the FFS delivery system is the lowest of the three delivery systems for outpatient services (see Exhibit IV.12). PCCM members utilize more outpatient services than either RBMC members or FFS members. Similar to utilization of inpatient services, utilization of outpatient services by FFS members has declined in recent years.

Exhibit IV.12
Outpatient Claims Per 1,000 Eligibles
For All CHIP Members By Delivery System
January 2002 - October 2004



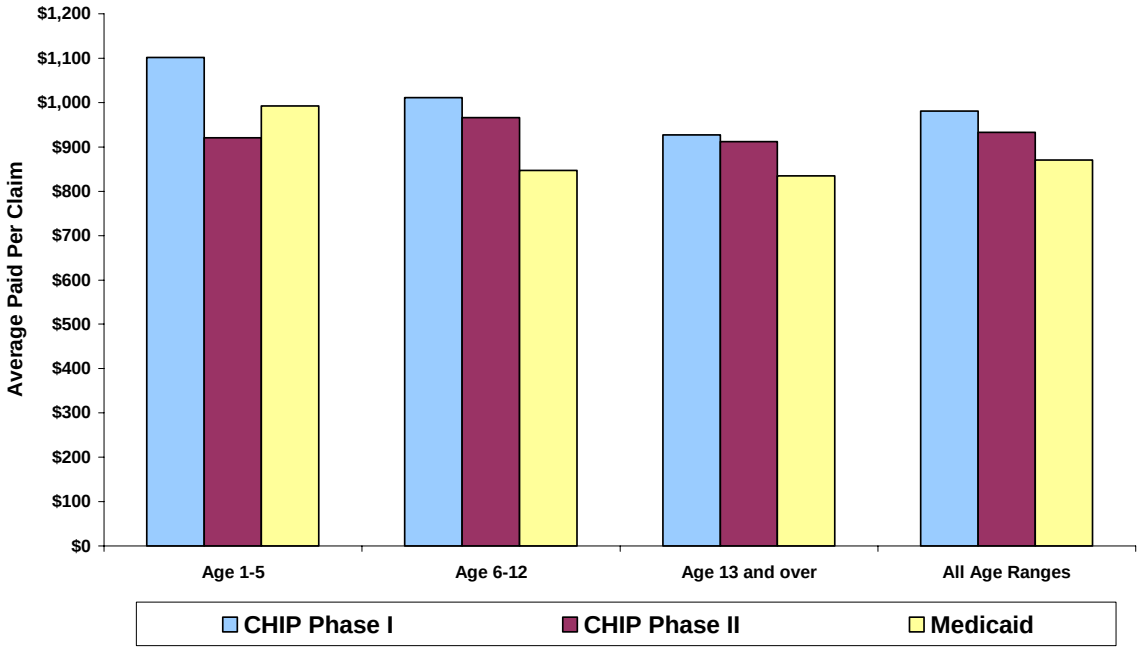
Source: MedInsight files available through December 2004.

Are there variations between the costs of hospital services for CHIP and Medicaid members by age group?

For inpatient hospital services in 2004, the average payment per day was highest for CHIP Phase I children ($981 across all ages) and lowest for Medicaid children ($870 across all ages). Children enrolled in CHIP Phase I have the highest average payment per day for each of the three age groups studied as well. Between Medicaid and CHIP Phase II, Medicaid has a higher average payment in the age one to five category but lower for children age six and higher.

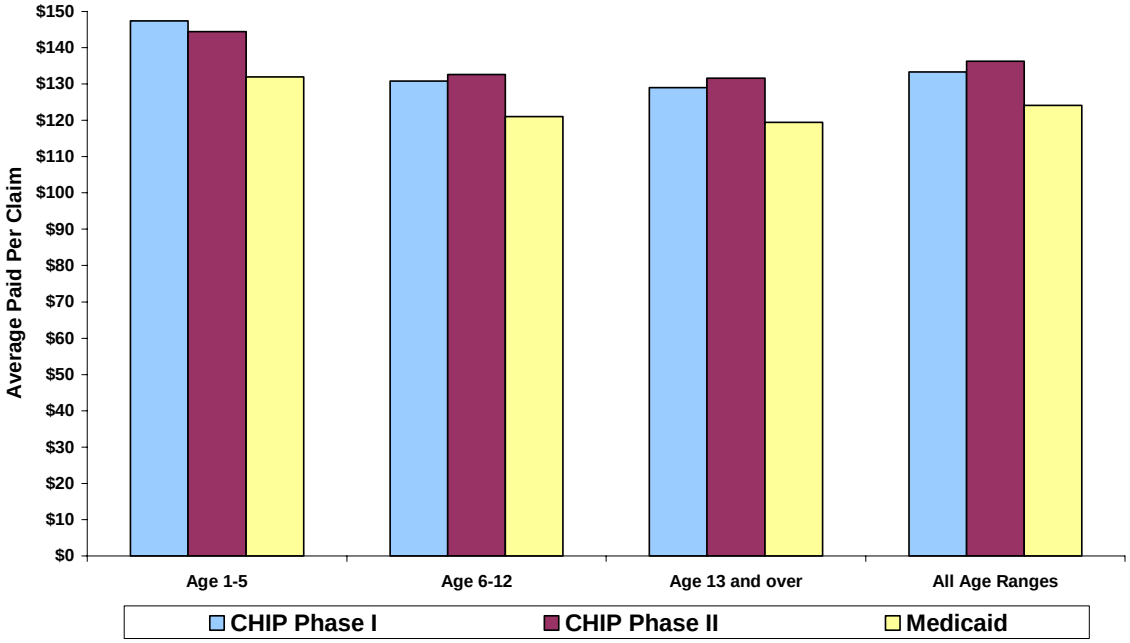
For outpatient hospital services in 2004, Medicaid has lower average payments per claim both overall and across each of the three age groups. Though CHIP Phase I children between the ages of one and five have higher average payments per claim than CHIP Phase II children, the opposite is true for children ages six and higher, where CHIP Phase II average payments per claim are higher than those for CHIP Phase I. All of these differences, however, are not too meaningful. The average payment per claim (all age groups) across all three programs for outpatient services is between $124 and $136.

Exhibit IV.13
Inpatient Hospital Average Paid Per Day
For Dates of Service in Calendar Year 2004



Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

Exhibit IV.14
Outpatient Hospital Average Paid Per Claim
For Dates of Service in Calendar Year 2004



Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

PHYSICIAN SERVICES

For this analysis, services provided by Physicians to CHIP members were classified into two major categories: services provided by a PMP (Primary Medical Provider) and services provided by a physician that is not classified as a PMP. A PMP serves as the coordinator of care for a child in CHIP or Medicaid. In the PCCM delivery system, these PMP's are paid a $3.00 monthly administrative fee to assume this responsibility. PMPs may include General Practitioners, General Pediatricians, Family Practitioners, OB/GYNs, and General Internists. Physicians may provide services in a clinic, public health agency, or as part of a group practice.

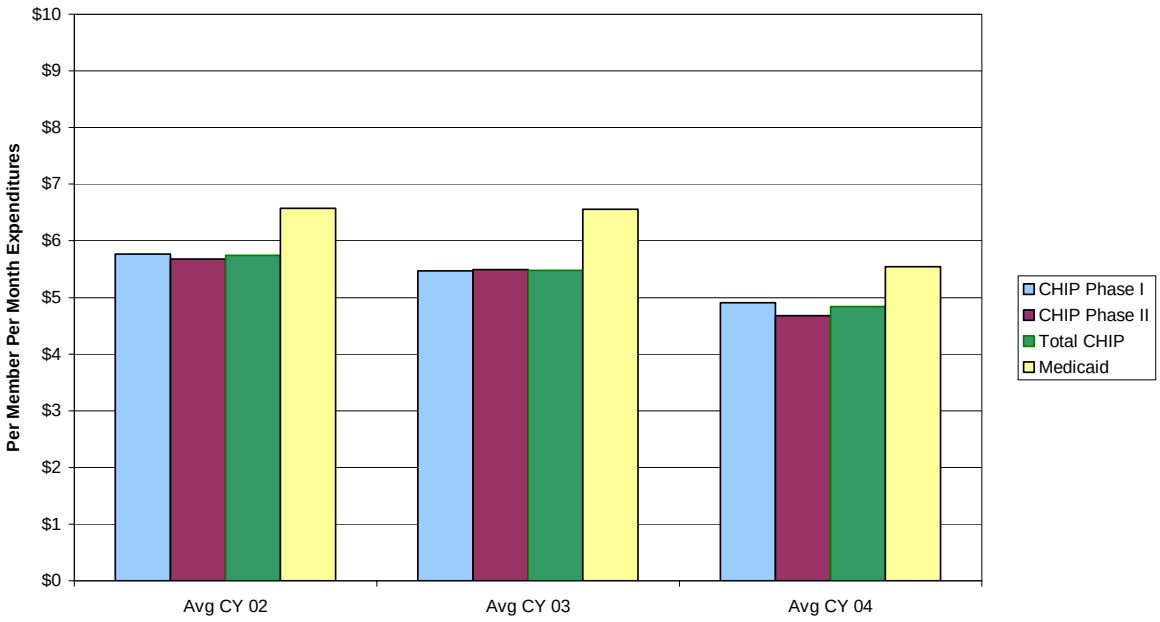
For the purposes of this study, physicians with the five specialties listed above are considered PMPs. All other types of physicians are classified into the "non-PMP" group, more commonly known as specialists.

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II and Medicaid children in the PCCM/FFS delivery systems for PMP and non-PMP physician services? Do expenditures relate to utilization trends?

The PMPM expenditures for PMP physician services are slightly higher for children enrolled in Medicaid than the two CHIP programs, but all three programs have averaged between $5.50 and $6.50 per member per month in the last three years (see Exhibit IV.15). CHIP PMPM expenditures fell slightly between CY 2002 and CY 2003, while Medicaid PMPM expenditures remained at CY 2002 levels. The further decline in CY 2004 for all three programs is most likely attributable to a lag in claims processing.

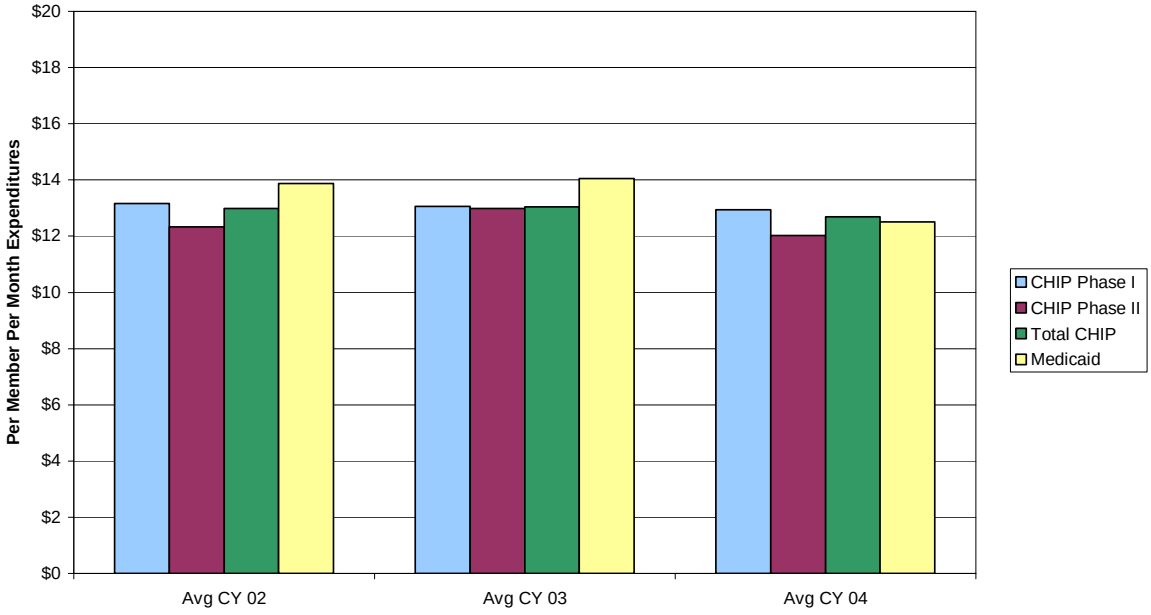
Comparing PMP expenditures to non-PMP expenditures based on per member per month costs, non-PMP expenditures are a little more than twice what PMP expenditures are (see Exhibit IV.16 as compared to Exhibit IV.15). However, the trends between CHIP Phase I, CHIP Phase II and Medicaid are the same for non-PMP services as they were for PMP services. Because non-PMPs include a wide variety of specialty services outside of the more routine types of check-up appointments fulfilled by PMPs, it is not surprising that the PMPM is higher for non-PMP provider services than PMP providers. The higher PMPM is primarily due to a higher average payment per claim for non-PMP services, since utilization of non-PMP services is only slightly higher than that found for PMP services (details shown on the following pages). Although the PMPM for non-PMP services was higher for Medicaid children than CHIP children in CY 2002 and CY 2003, all three programs had about the same PMPM in CY 2004.

Exhibit IV.15
PMP Physician Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004



Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

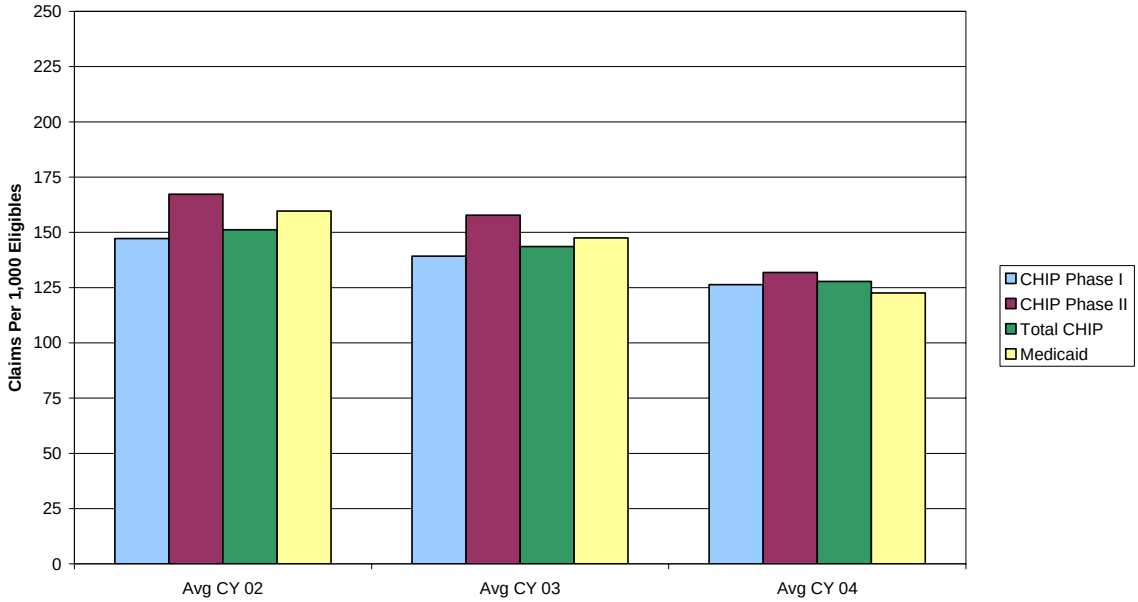
Exhibit IV.16
Non-PMP Physician Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004



Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

The decline in PMPM expenditures for PMP services from CY 2002 to CY 2004 appears to be due to a downward trend of utilization for these services. Utilization of PMP services fell in each of the years after CY 2002 and for each of the programs. Relative to the whole CHIP program, Medicaid utilization has fallen faster than that reported for both CHIP programs. The information in CY 2004, however, may be due to some claims not yet reported in the Hoosier Healthwise database of claims.

Exhibit IV.17
PMP Physician Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004

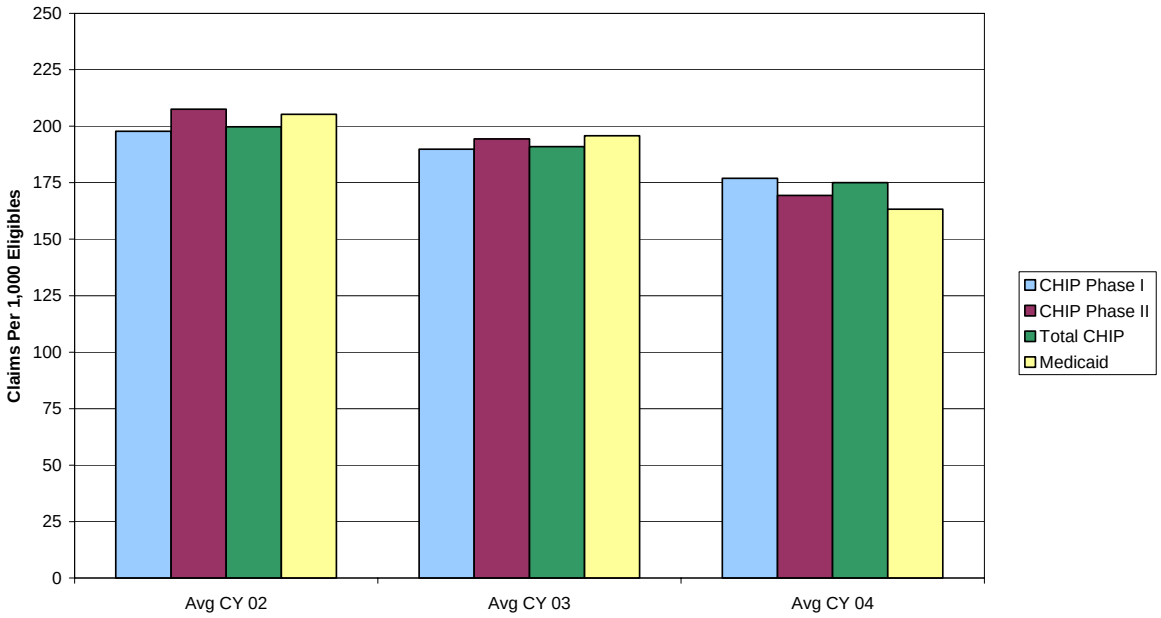


Source: MedInsight files available through December 2004. Shadow claims (RBMC delivery system) included.

The findings shown in Exhibit IV.17 above match those found in our analysis of utilization of PMP physician services by age group, reported in Chapter III. The decline in utilization of claims per 1,000 eligibles found above correlates to Exhibits III.7 through III.10 where we found that the percentage of children that had at least one PMP visit in calendar year 2004 was slightly lower than that found for calendar year 2003. This was true for each of the age groups studied—children age 1, age 2, age 3, age 4, age 5, ages 6-12, and ages 13-18—in the PCCM and FFS delivery systems.

In absolute terms, utilization of non-PMP services is greater than utilization of PMP services (see Exhibit IV.18 on the next page as compared to Exhibit IV.17). For example, in CY 2002 there were 33% more claims for non-PMP services than there were claims for PMP services from children enrolled in either CHIP program. As was the case with PMP services, utilization of non-PMP services appears to have fallen the fastest for the children in Medicaid.

Exhibit IV.18
Non-PMP Physician Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004



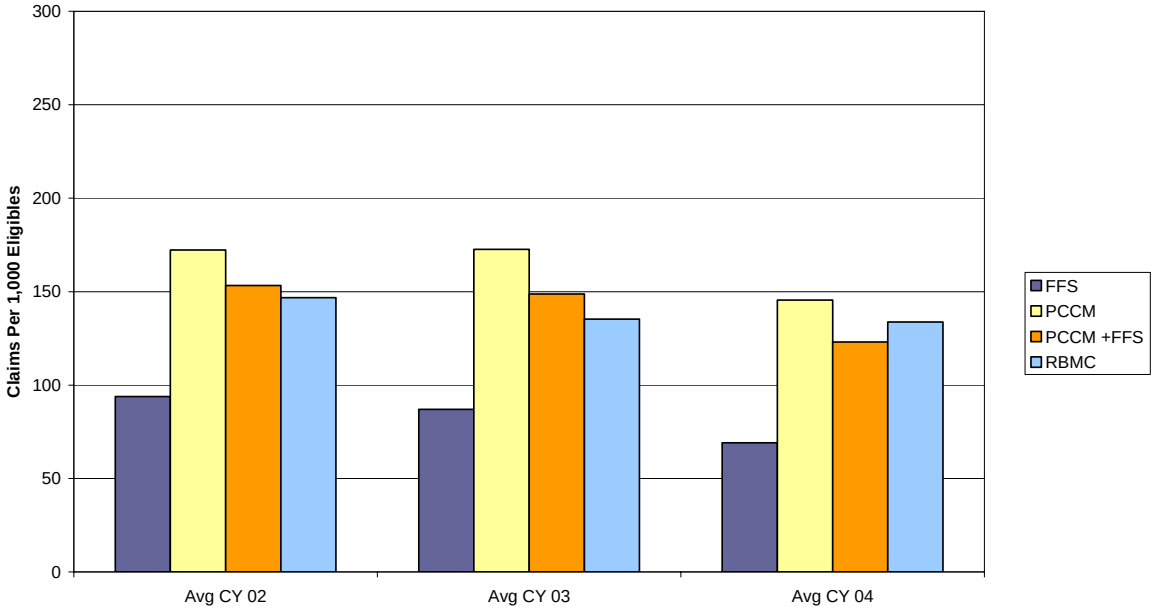
Source: MedInsight files available through December 2004. Shadow claims (RBMC delivery system) included.

How does the utilization of physician services for CHIP members compare across the three delivery systems?

For both PMP and non-PMP services, CHIP member utilization is higher for the PCCM delivery system than it is for either the FFS or RBMC delivery systems (see Exhibits IV.19 and IV.20 on the next page). One might expect utilization of physician services to be low from the FFS population, because children in this group tend to be in FFS for a short period of time before they move into PCCM or RBMC. In other words, those in FFS may not be there long enough to utilize many physician services. For RBMC enrollees, it is expected that as more children move to or automatically enroll into the RBMC delivery system, the managed care organizations will be working to ensure that well-child visits are coordinated to avoid preventable outcomes. This should show an increase in the utilization of PMP visits per 1,000 in RBMC in the future.

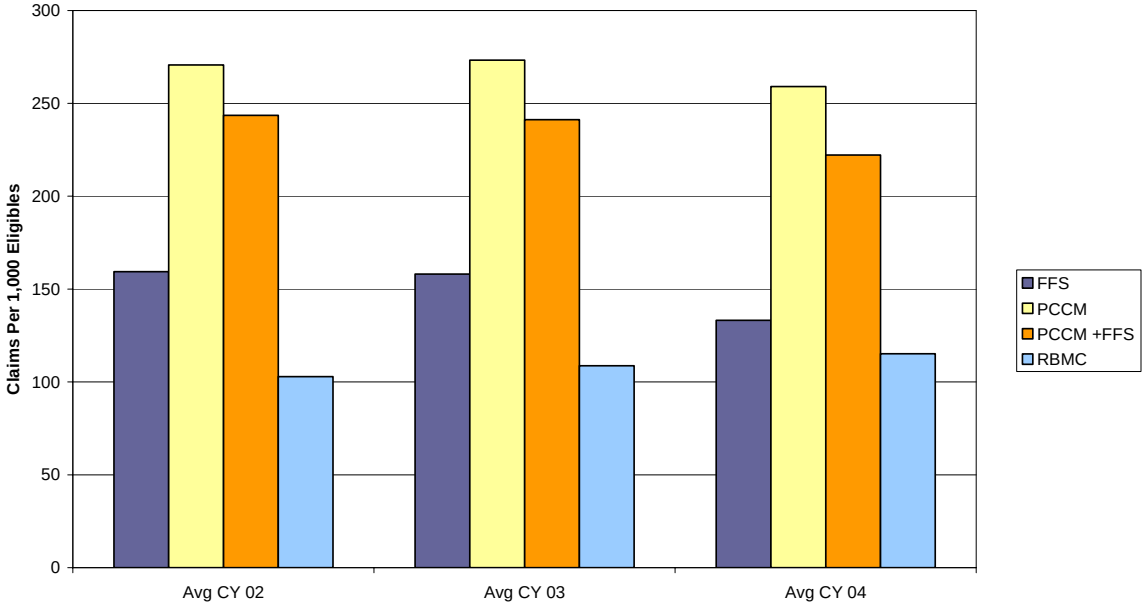
For non-PMP services, there is a large difference between utilization in the PCCM delivery system and utilization in the RBMC delivery system. Two factors may be influencing this result. Since non-PMP services are often provided in clinics or public health agencies, managed care organizations may not utilize these providers as much as the PCCM delivery system. The other possibility is that these services are being utilized but MCOs are not properly reporting claims for these services in a timely manner, though the consistent trend across the three years would lead one to assume that this is not a large issue.

Exhibit IV.19
PMP Claims Per 1,000 Eligibles
For All CHIP Members By Delivery System
January 2002 - October 2004



Source: MedInsight files available through December 2004.

Exhibit IV.20
Non-PMP Claims Per 1,000 Eligibles
For All CHIP Members By Delivery System
January 2002 - October 2004

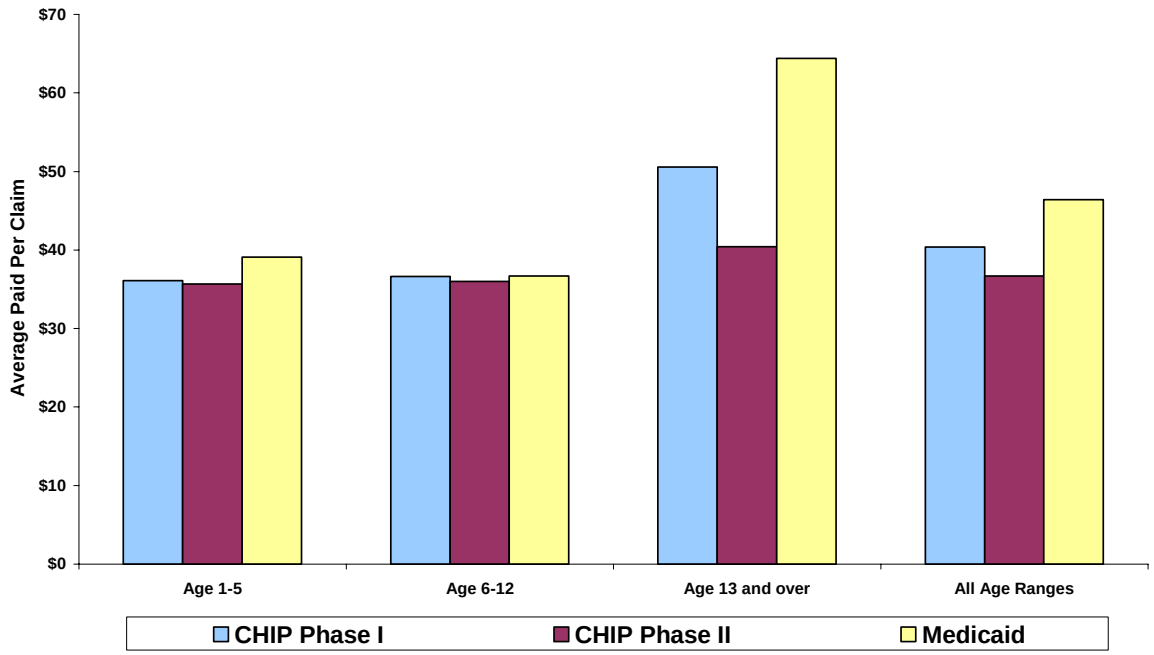


Source: MedInsight files available through December 2004.

Are there variations between the costs of physician services for CHIP and Medicaid members by age group?

For children between the ages of one and twelve there is little variation in the average payment per claim between CHIP and Medicaid members. The average payment per claim in this group for PMP services is between $37 and $46 (see Exhibit IV.21). For teenagers, the average payment per claim rises for all three programs but rises the most for Medicaid members and the least for CHIP Phase II members. This same pattern was reported last year for CY 2003.

Exhibit IV.21
PMP Physician Average Paid Per Claim
For Dates of Service in Calendar Year 2004

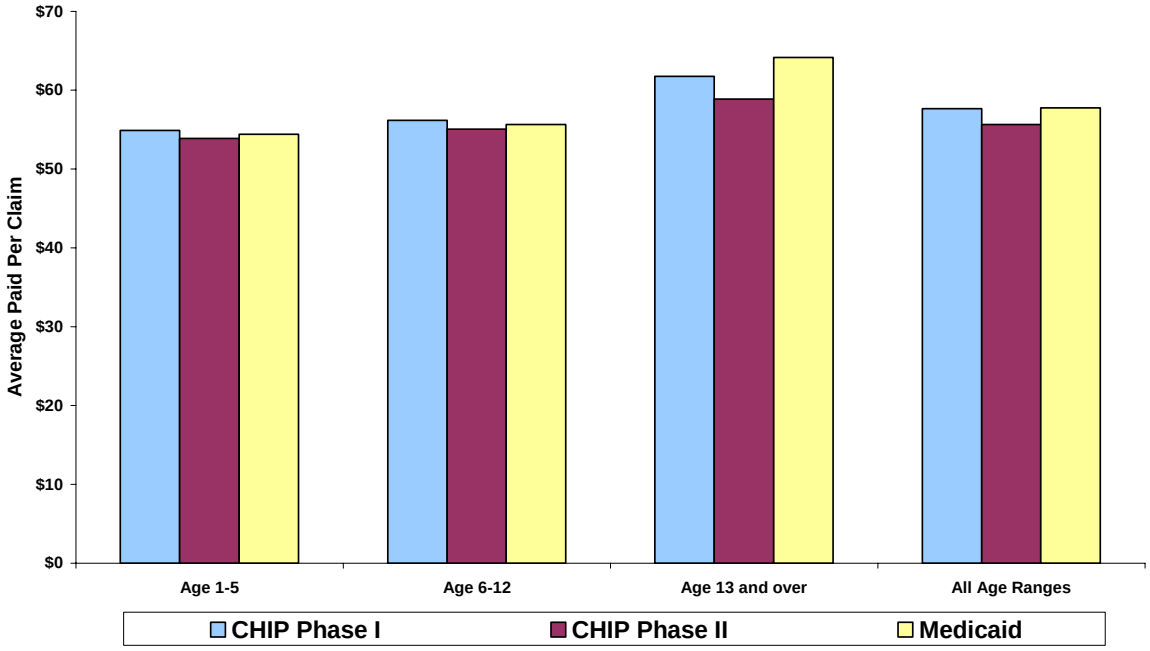


Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

Average payments for non-PMP services are consistently higher than those for PMP services across all age groups. Average payments for children age one to twelve are approximately 50% higher for non-PMP services than they are for PMP services. This difference is not as large for the teenager group.

As is the case for PMP services, average payments for children between age one and twelve show little variation, while average payments rise in all programs for the teenager group. Overall, Medicaid members and CHIP Phase I members have similar average payments across all age groups with CHIP Phase II members being slightly below the other two.

Exhibit IV.22
Non-PMP Physician Average Paid Per Claim
For Dates of Service in Calendar Year 2004



Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

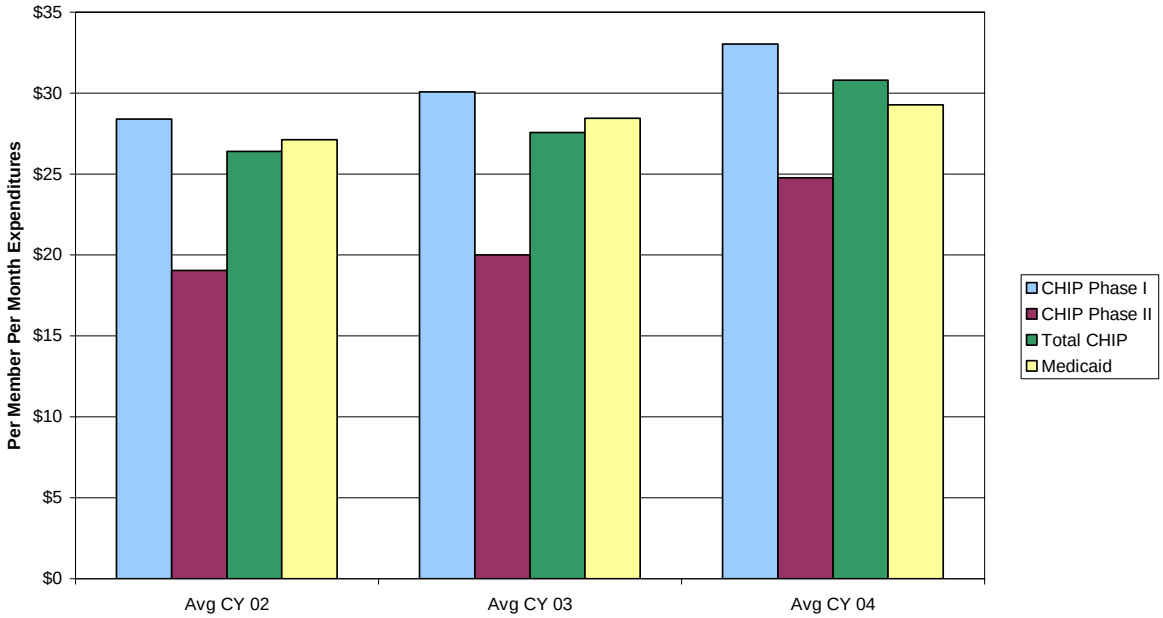
PHARMACY SERVICES

As reported in Chapter III, about 70% of children in CHIP had at least one prescription in CY 2004. The per member per month expenditures have grown about 15% from CY 2002 to CY 2004 in CHIP, but this is almost entirely due to growth in the CHIP Phase I PMPM. Even so, the PMPM between CHIP children ages one through 18 and Medicaid children of the same age is quite similar.

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II and Medicaid for pharmacy services? Do expenditures relate to utilization trends?

PMPM expenditures for the total CHIP population have been very similar to those for the Medicaid population over the past three years. However, when considered independently, CHIP Phase I PMPM expenditures and CHIP Phase II PMPM expenditures show little similarity. Phase II PMPM expenditures are on average about $10 lower than Phase I PMPM expenditures. Lower utilization of pharmacy services in the CHIP Phase II population and a more restrictive benefit package (over-the-counter drugs are not covered in CHIP Phase II) both contribute to lower PMPM expenditures for CHIP Phase II children.

Exhibit IV.23
Pharmacy Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004

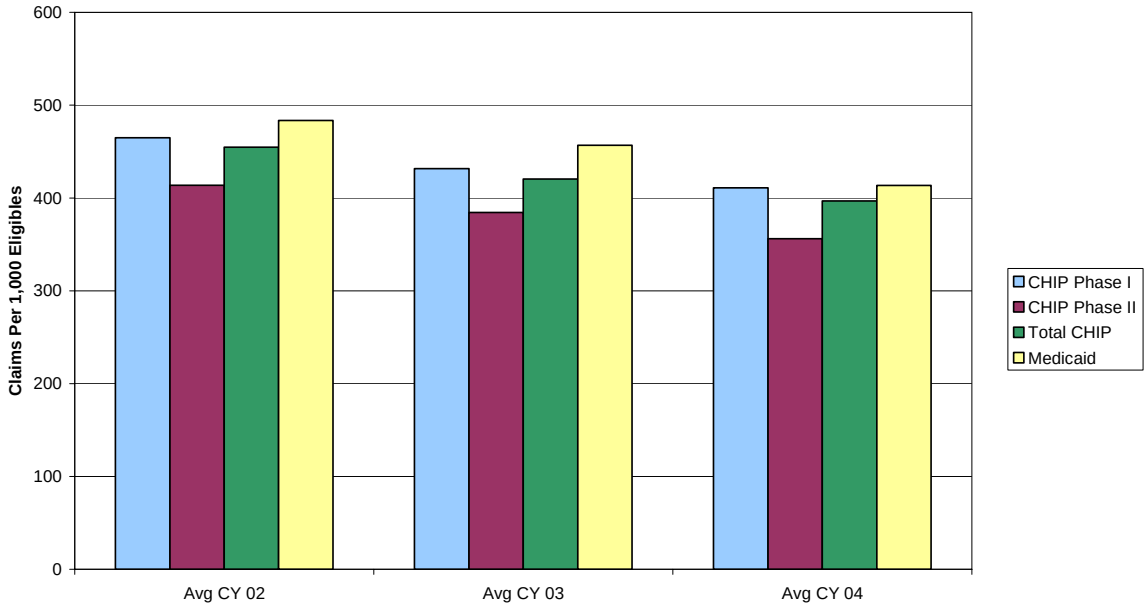


Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

PMPM expenditures are rising for all program types, while utilization is falling. Exhibit IV.24 on the next page compares pharmacy claims per 1,000 for the three program types. In CY 2002, total CHIP and Medicaid utilization was between 450 and 500 claims per 1,000, but

by CY 2004 utilization for CHIP and Medicaid has fallen to around 400 claims per 1,000. The lower utilization may be due in part to state efforts in implementing a preferred drug list and prior authorizations for certain scripts. The rising PMPM expenditures and falling utilization, therefore, suggest that the expenditure increase is due to average payments per claim rising.

Exhibit IV.24
Pharmacy Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004



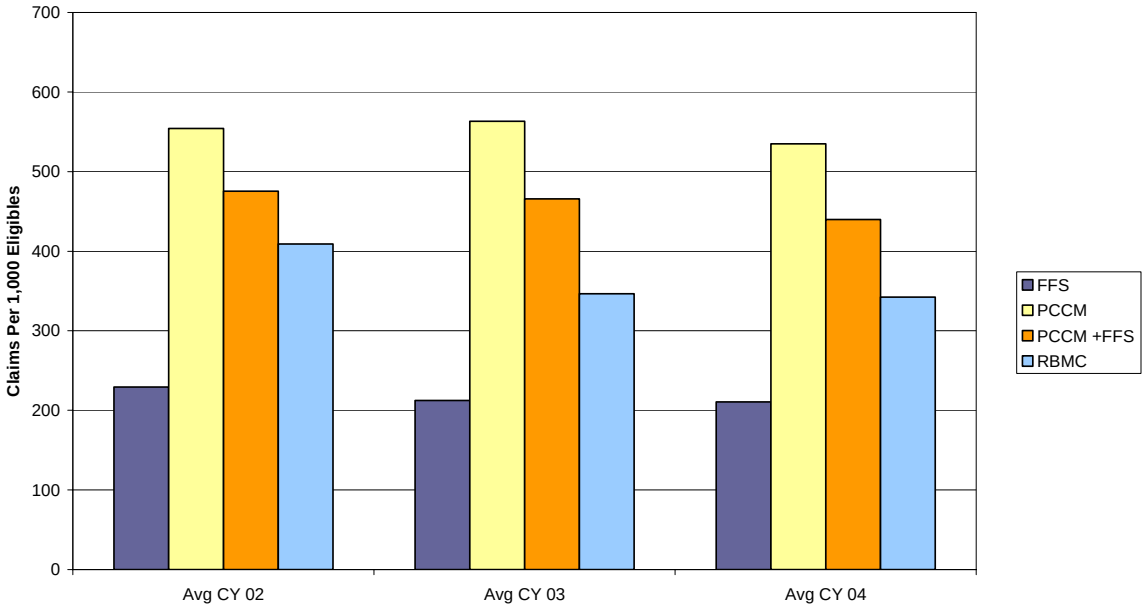
Source: MedInsight files available through December 2004. Shadow claims (RBMC delivery system) included.

How does the utilization of pharmacy services for CHIP members compare across the three delivery systems?

Utilization of pharmacy services is consistently higher in the PCCM delivery system than either FFS or RBMC. On average, there are approximately 200 claims per 1,000 per month more in PCCM than there are in RBMC, the delivery system with the lowest utilization. FFS utilization falls in between PCCM and RBMC.

Lower utilization of pharmacy scripts due to a concentrated effort by the MCOs as well as overall growth in members in the RBMC population are probably driving the overall decline in utilization seen in Exhibit IV.25.

Exhibit IV.25
Pharmacy Claims Per 1,000 Eligibles
For All CHIP Members By Delivery System
January 2002 - October 2004



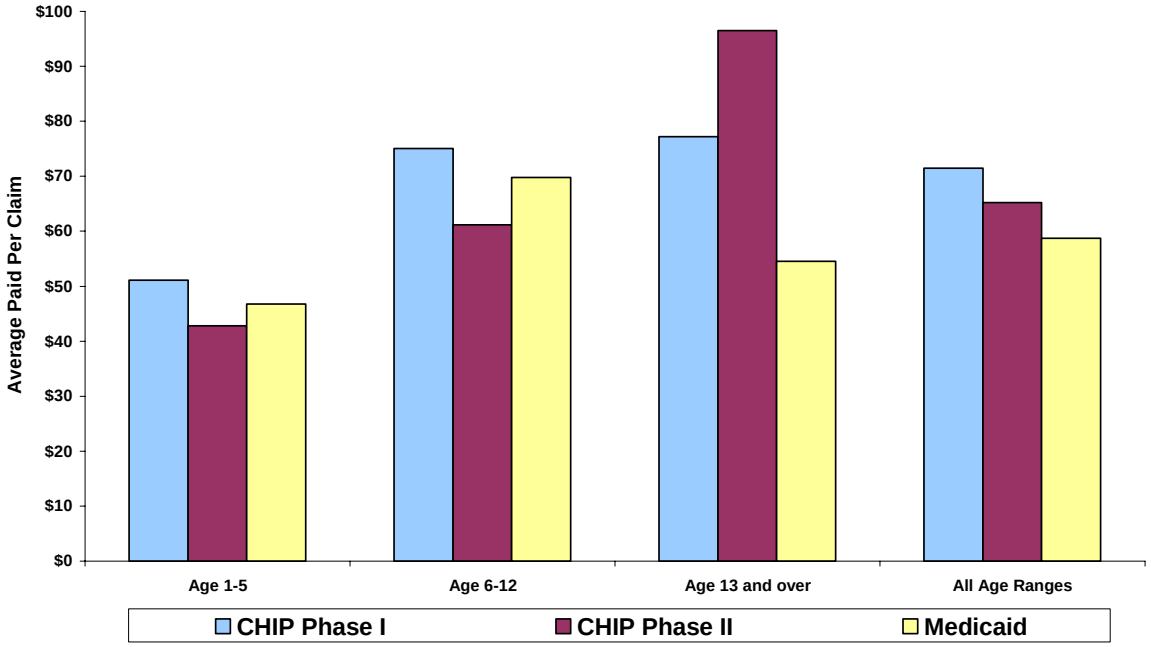
Source: MedInsight files available through December 2004.

Are there variations between the costs of pharmacy scripts for CHIP and Medicaid members by age group?

Between CY 2003 and CY 2004, the average payment per claim has increased for all age groups. In prior reports, EP&P reported that children under age five always had the least expensive pharmacy claims, while teenagers had the most expensive. In CY 2004, children under age five still have the least expensive pharmacy claims, but for the Medicaid population this is the first year that children age 6-12 have significantly higher average per claim payments than teenagers (see Exhibit IV.26 on the next page).

The unusually high average payment per claim figure for CHIP Phase II children between the ages of 13 and 18 can be attributed to seven outlier (extraordinarily high-cost) claims filed in the beginning of CY 2004. Outliers were included in all the calculations for this chapter, and CHIP Phase II low volume of claims compared to the other two programs makes it particularly vulnerable to the effects of a few outliers. If these outlier claims were excluded, the CHIP Phase II trend would be similar to that shown for CHIP Phase I for the teenager group.

Exhibit IV.26
Pharmacy Average Paid Per Claim
For Dates of Service in Calendar Year 2004



Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

DENTAL SERVICES

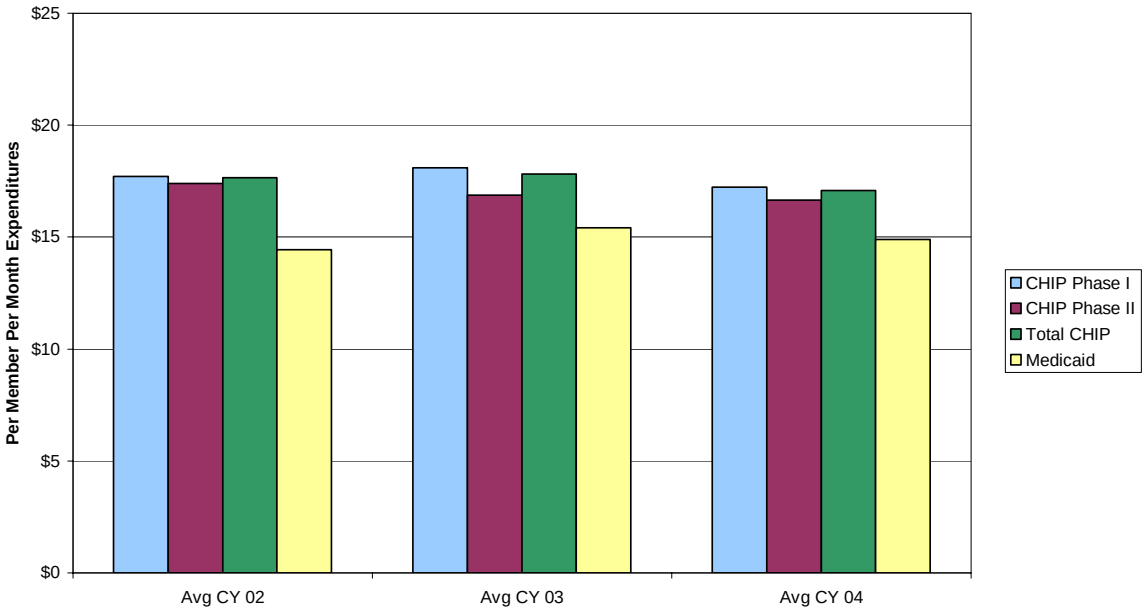
EP&P has consistently reported over the years that utilization of dental services for CHIP Phase II children has been slightly higher than that shown for CHIP Phase I and much higher than that shown for Medicaid children. This year is no exception. The higher utilization, however, does not actually translate to much higher expenditures on a per member per month basis for dental services.

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II and Medicaid for dental services? Do expenditures relate to utilization trends?

PMPM expenditures for dental services for Medicaid members have historically been lower than PMPM expenditures for either CHIP program. The most recent data suggest that this is still the case, yet there is evidence that this gap is disappearing as the difference in PMPM expenditures has shrunk from $4 to $2 in CY 2004.

Unlike pharmacy services, the PMPM for dental services has remained relatively constant over the last three years, at about $17 per member per month for CHIP and $15 for Medicaid children (see Exhibit IV.27 below).

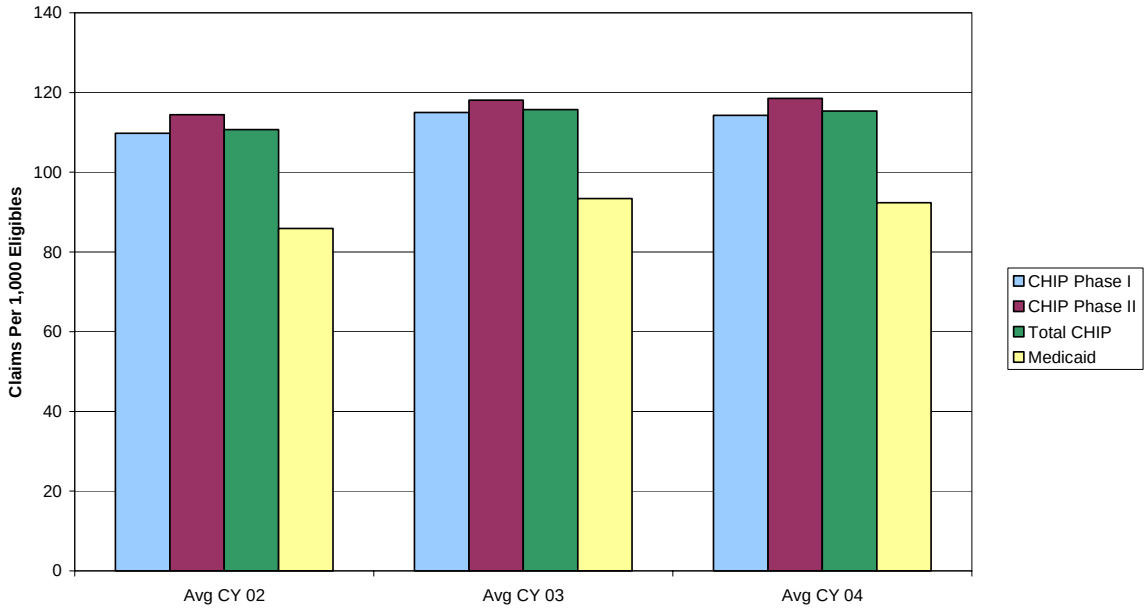
Exhibit IV.27
Dental Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004



Source: MedInsight files with payments made through December 2004.

Given that the PMPM values have stayed consistent over the most recent three-year period, it is not surprising to find that the utilization per 1,000 members has also been consistent. Utilization of dental services does not vary between CHIP Phase I members and CHIP Phase II members. However, utilization of these services is lower for Medicaid members than it is for CHIP members.

Exhibit IV.28
Dental Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004

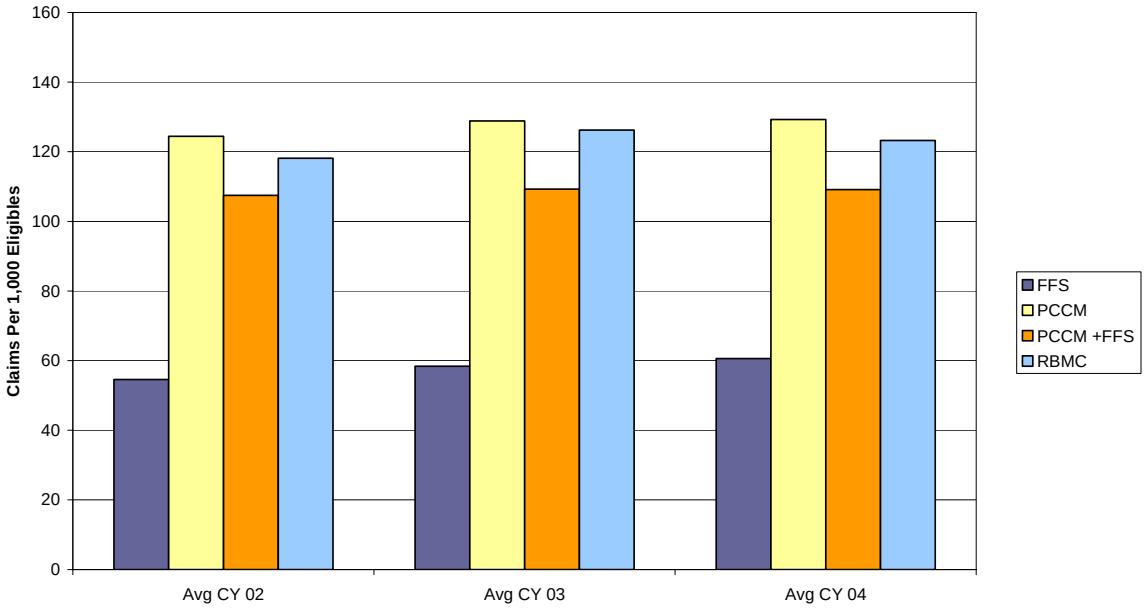


Source: MedInsight files available through December 2004.

How does the utilization of dental services for CHIP members compare across the three delivery systems?

The PCCM and RBMC delivery systems share rates of about 120 claims per 1,000 members for the utilization for dental services and this has been consistent for the last three years. These delivery systems have utilization that is more than twice the utilization found for FFS members. The low utilization of the FFS members was also apparent for physician services. The reason most likely is that members tend not to stay in FFS for very long. For the purposes of analyzing utilization here, the members categorized in the RBMC delivery system are those members usually categorized in the RBMC system for the other services they receive. This is noted because dental services are not covered by managed care organizations in the RBMC delivery system.

Exhibit IV.29
Dental Claims Per 1,000 Eligibles
For All CHIP Members By Delivery System
January 2002 - October 2004



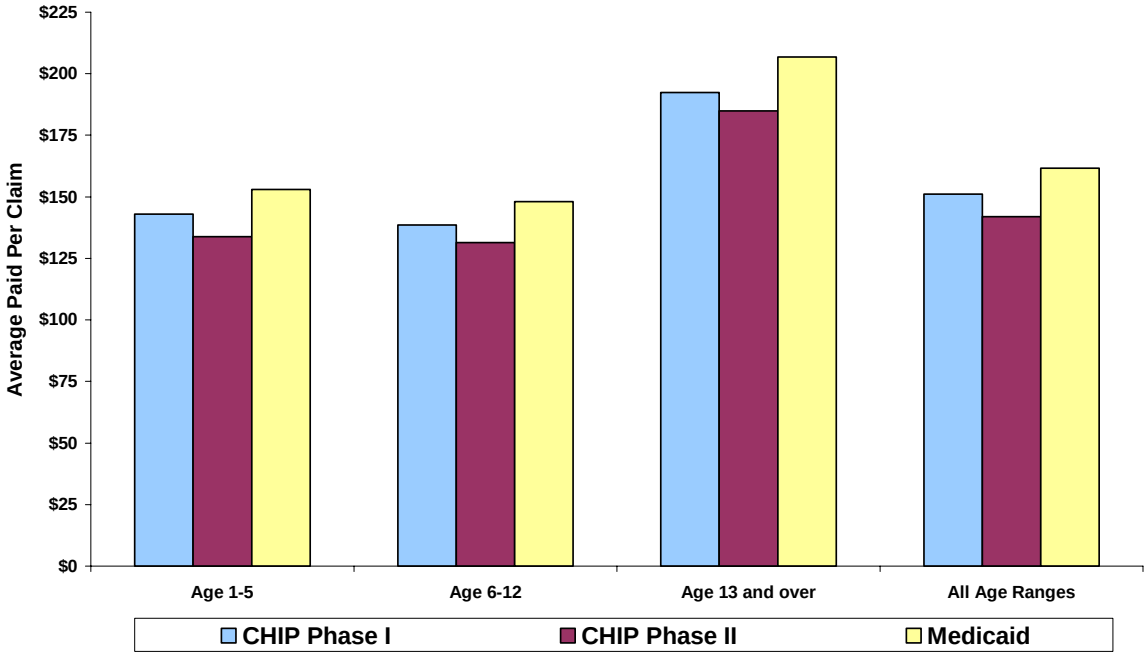
Source: Dataprobe files available through December 2004.

Are there variations between the costs of dental services for CHIP and Medicaid members by age group?

The average paid per claim is relatively consistent between CHIP and Medicaid for children in the age 1-5 and 6-12 groups at an average between $130 and $150. It is not surprising that the average paid per claim is higher for teenagers, as dental needs increase for this age group. For CHIP children, the average paid per claim is around $200 and for Medicaid children it is slightly higher at around $210.

These findings are similar to those found by EP&P in 2003, both the average payment amounts and the trends across the age groups. Unlike other types of services, average payments per claim for dental services have remained relatively constant.

Exhibit IV.30
Dental Average Paid Per Claim
For Dates of Service in Calendar Year 2004



Source: MedInsight files with payments made through December 2004. Shadow claims (RBMC delivery system) excluded.

OTHER SERVICES

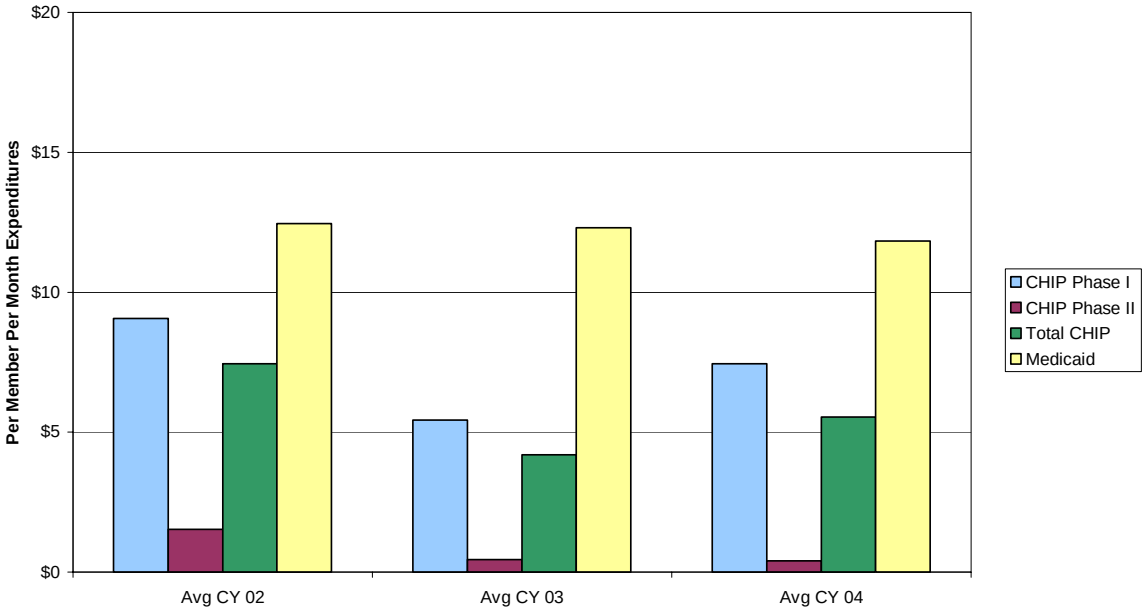
Other services include all services with expenditures that do not fall into the previously discussed major categories. Services in this category include inpatient psychiatric services, mental health services outside of the hospital setting, therapies, case management, and vision. The largest components of this "other services" category are inpatient psychiatric and mental health services (based on expenditures). Neither of these services is included in the capitation payments made to MCOs. As such, the PMPM findings shown in this section are for members in the PCCM and FFS delivery systems only.

The other services mentioned above are divided by the way they are reported to the State. Institutional services and home health services are reported on one type of claim form; the remaining services are reported on another type of claim form. Each group is analyzed separately below.

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II, and Medicaid for institutional and home health services?

The largest category of expenditures in this group is inpatient psychiatric hospital services. Relatively speaking, however, the total expenditures for these services is small (4.1% of total CHIP service expenditures in federal fiscal year 2004). Among the three programs, however, PMPM expenditures vary significantly (see Exhibit IV.31 on the next page). Expenditures for CHIP Phase II in this category are nearly zero, because CHIP Phase II does not cover most services in this category, while expenditures for Medicaid are over $10 per member per month. Compared to PMPM expenditures, these translate to around 1% of total expenditures in CHIP Phase II and between 8% and 9% of total expenditures for Medicaid. CHIP Phase I expenditures fall midway in between CHIP Phase II and Medicaid. This is a direct result of higher utilization of inpatient psychiatric services for children in Medicaid than for children in CHIP Phase I.

Exhibit IV.31
Other Services (UB-92) Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004

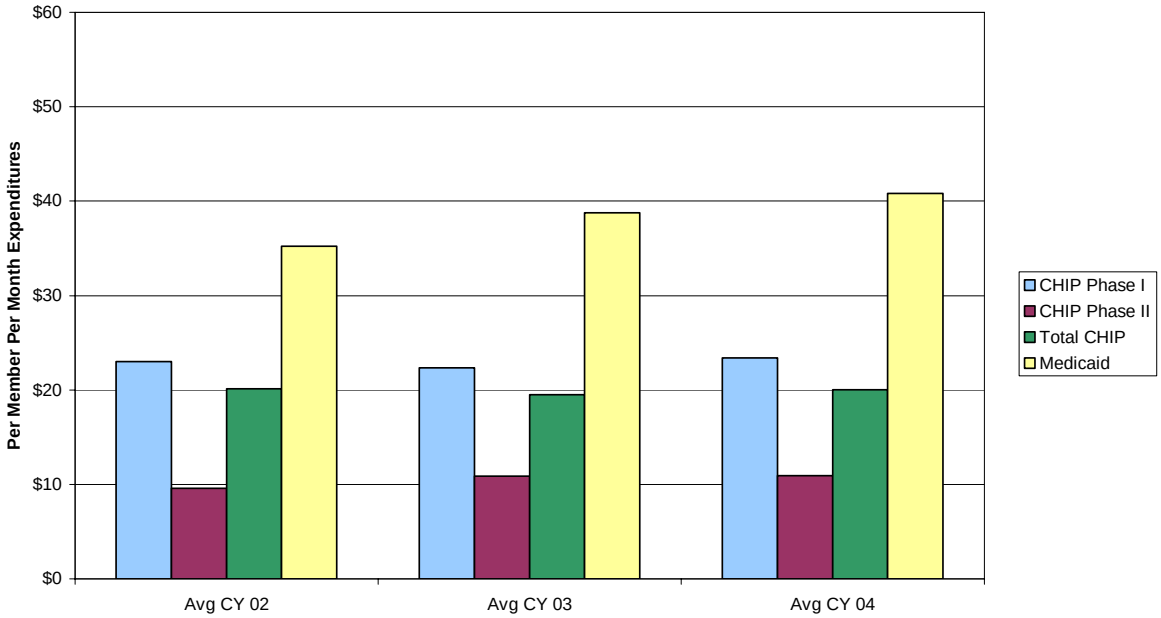


Source: MedInsight files with payments made through December 2004.

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II, and Medicaid for the remaining "other" services?

Unlike the institutional and home health services, expenditures for the remaining other services comprise a larger portion (15.8%) of total CHIP service expenditures in FFY 2004. These services are a wide variety of professional services provided outside of an institutional setting. The largest service expenditure in this group is for mental health services (52% of total expenditures in group). Other high-expenditure categories include vision-related services (10% of total expenditures in group) and speech therapy (8% of total expenditures in group). As seen with the institutional-related services in Exhibit IV.31, Medicaid children have the highest PMPM expenditures for this group of professional services (about $40 PMPM), and CHIP Phase II has the lowest PMPM expenditures ($10 PMPM). See Exhibit IV.32 on the next page.

Exhibit IV.32
Other Services (CMS-1500) Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2004



Source: MedInsight files with payments made through December 2004.

CHAPTER V
EVALUATION OF QUALITY DATA MEASURES RELATED TO HOOSIER HEALTHWISE MONITORING ACTIVITIES

INTRODUCTION

Chapter V focuses on EP&P Consulting's (EP&P's) review of quality initiatives undertaken by the state in their efforts to monitor the Hoosier Healthwise program. Children enrolled in CHIP are part of the larger Hoosier Healthwise program with respect to the way that services are delivered to them. That is, the delivery systems used to provide services to CHIP members—mainly through the Risk-Based Managed Care (RBMC) and Primary Care Case Management (PCCM) programs—are the same for children in CHIP as they are for children in other parts of Hoosier Healthwise as well as most adults in Hoosier Healthwise. As such, the CHIP Office is able to work directly with members of the Office of Medicaid Policy and Planning (OMPP) staff in efforts to jointly monitor the programs where children are enrolled.

There are a number of participants in the overall quality monitoring process for the Hoosier Healthwise program. These include:

- State staff from the CHIP Office and the OMPP
- The managed care organizations (MCOs) participating in the RBMC delivery system (in 2004, these included Managed Health Services, Harmony Health Plan, and MDWise)
- AmeriChoice, the administrator of Prime*Step*, the PCCM program
- Navigant Consulting, an outside vendor who is the monitoring contractor for the Hoosier Healthwise program
- Market Measurement, an outside contractor who is the survey administrator for the annual member and provider satisfaction surveys for members enrolled in the PCCM program

EP&P reviewed quality initiatives that were performed by each of these entities—either individually or as a group. Key areas studied, which will be discussed in more detail in this chapter, include:

- A review of the results of the 2004 member satisfaction surveys conducted by the MCOs and Market Measurement, along with a comparison of findings in Indiana to responses among members in Medicaid and CHIP programs nationwide. EP&P's specific focus was on member responses from CHIP families versus other members of Hoosier Healthwise.

- A review of the results of the 2004 Primary Medical Provider (PMP) satisfaction survey conducted by Market Measurement

- An examination of the findings from a HEDIS study conducted by the MCOs and how these data compared to national findings (as tabulated in a report by Navigant Consulting). EP&P's focus was on HEDIS measurements that specifically pertain to children.

- A review of statistics collected by AmeriChoice on the Hoosier Healthwise Helpline, specifically as it pertains to quality concerns voiced by members

- A summary of issues discussed at Quality Improvement Meetings in 2004

KEY HIGHLIGHTS

Overall, our evaluation of the monitoring activities within the Hoosier Healthwise program yielded several key findings:

- Overall, children in CHIP continue to give high ratings in the annual member satisfaction survey. In most areas studied, Indiana's CHIP members give higher marks than CHIP members in other programs nationwide. In rating their child's health plan, more than 90% of parents of CHIP children in both PCCM and RBMC rated it as "excellent" or "very good". Similar findings occurred for the rating of their child's personal doctor.

- Satisfaction among PMP providers, as found in their annual survey, has gone down slightly (37% were at least somewhat dissatisfied). Areas cited that caused the dissatisfaction rating were the increasing patient loads of Hoosier Healthwise members and concern with the reimbursement rates.

- When compared to national HEDIS trends for Medicaid managed care plans, Indiana's MCOs rank consistent with national figures on children's access to primary care and well-child visits. Areas for improvement for Indiana's health plans are related to immunization rates.

- The percentage of calls to the Hoosier Healthwise Member Helpline with respect to quality remains consistently low, as only 2% of all calls were related to quality issues. This has been a consistent finding for the last five years.

- The Quality Improvement Committee has been focused in the last year on improving shadow claims submissions by the MCOs as well as gaining a better understanding of who is using emergency room services and whether or not some of these members can be guided to other locations to receive services when they are non-emergent.

DISCUSSION OF SPECIFIC MONITORING ACTIVITIES

Member Satisfaction Survey

The OMPP contracted with Market Measurement to conduct a member satisfaction survey of Hoosier Healthwise members enrolled in the PCCM delivery system as of December 31, 2003. The sample included members from all counties who were enrolled in the program greater than six months, regardless if medical services were obtained. Surveys were based on telephone interviews administered by Market Measurement. The survey instrument was a modified version of the national CAHPS (Consumer Assessment of Health Plans Study) health survey tool tailored to the Medicaid population. Questions were asked of all Hoosier Healthwise members stratified by age and length of enrollment in Hoosier Healthwise. Some questions were asked specifically of the parents/guardians of CHIP Phase I and CHIP Phase II members.

The three MCOs serving Hoosier Healthwise members also conducted member satisfaction surveys using the same survey model. The results from questions on these surveys, however, were only stratified on the adult and child populations. The CHIP population was not specifically identified from the child population. However, the results of all children in Hoosier Healthwise may be indicative of feedback from the CHIP population.

The findings from these surveys are shown in two subsections below. The first section compares results from CHIP members enrolled in Prime*Step* (the PCCM program) to all Hoosier Healthwise members enrolled in Prime*Step* as well as national results for CHIP programs nationwide. The second section compares the feedback from questions on the child survey administered to Hoosier Healthwise members enrolled in Prime*Step* as well as the three MCOs.

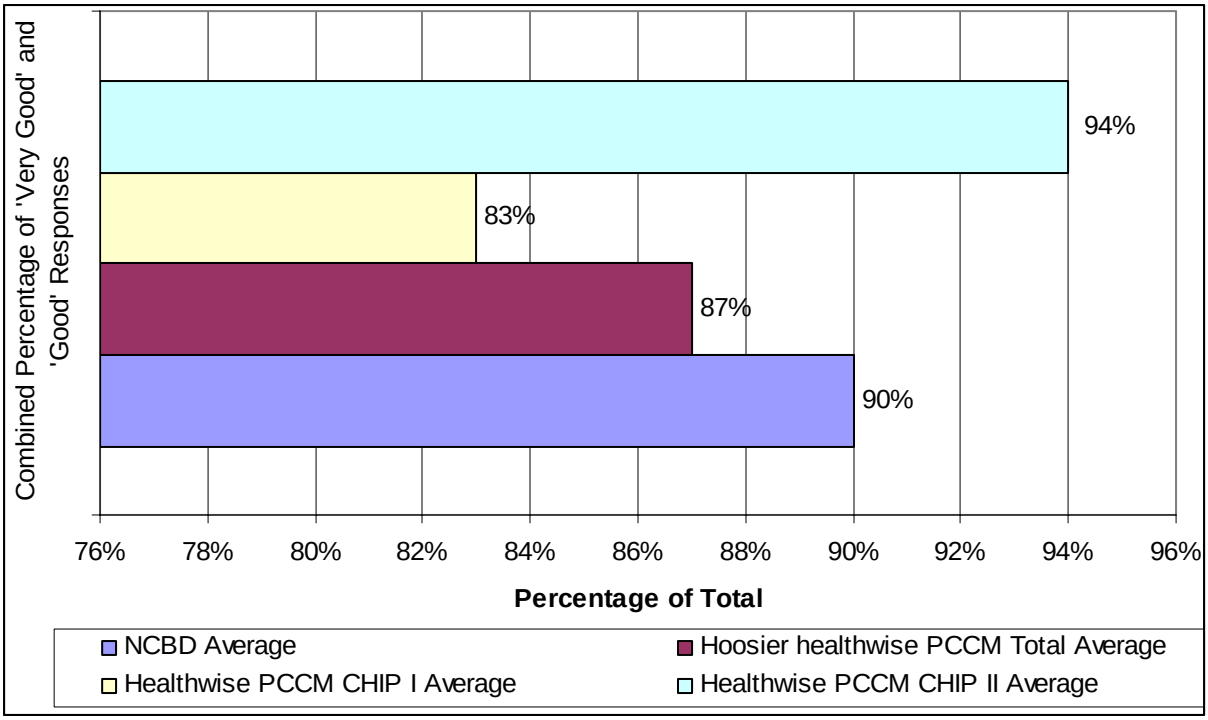
Results from CHIP Members Enrolled in PrimeStep as Compared to CHIP Members Nationwide

Note: There were slight differences in how responses were aggregated between the nationwide CAHPS health survey tool and the Indiana-specific modified CAHPS tool. Therefore, comparisons to national measures should be viewed from the perspective of relative comparisons versus absolute number comparisons.

Similar to last year's findings, satisfaction rates among members of Indiana's CHIP program are near other Hoosier Healthwise member satisfaction rates and frequently above satisfaction rates for CHIP enrollees nationwide. The following criteria were analyzed to compare the satisfaction levels of CHIP Prime*Step* members to all Prime*Step* members as well as satisfaction levels of families of children in Medicaid programs nationwide.

- Rating of Member's Overall Health Care. The percentage of Hoosier Healthwise members rating their overall health care as "very good" or "good" exceeded the national response rate among children in CHIP program. Seventy percent of Hoosier Healthwise respondents overall rated their health care as "very good", but CHIP Phase I members rated it as 72% and CHIP Phase II members rated it as 79%. All of these exceed the national rating of 60%. When adding together responses of "good" and "very good", 94% of parents of children in CHIP Phase II gave these ratings versus 83% in CHIP Phase I. The national average among CHIP children was 90%. It should be noted, however, that these findings are misleading. Members are asked to provide a ranking of 1 to 10 to this question, with a score of 9 or 10 indicating "very good". On the national survey, a "good" is classified as a score of 7 or 8. On the Hoosier Healthwise survey, a "good" is classified as a score of 8 only. Thus, the national data includes more CHIP children in the categorization of the "good" response category. (See Exhibit V.1 below for more details).

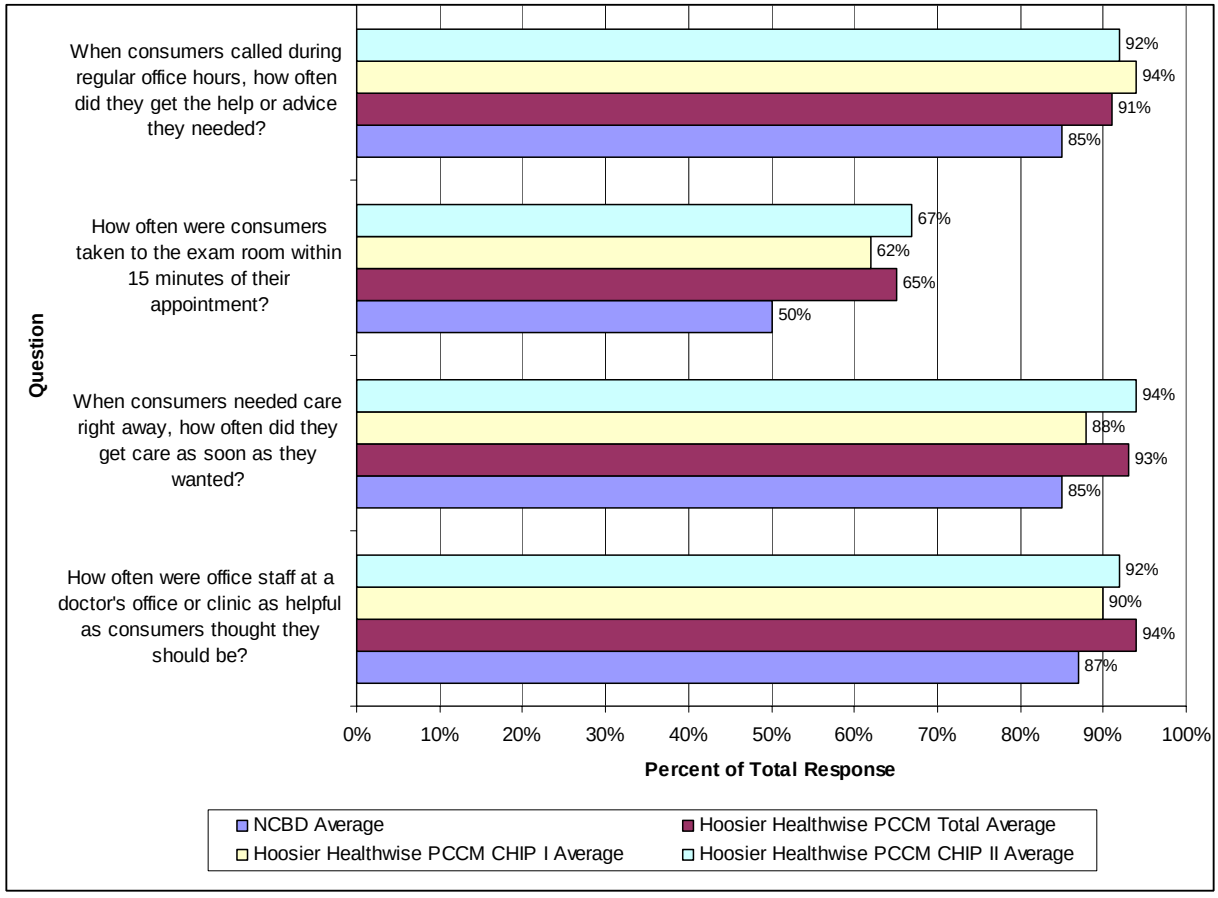
Exhibit V.1
Members' Ratings of Their Health Care
Percentage of Respondents who Stated "Very Good" or "Good"



Source for National Data: National CAHPS Benchmarking Database (NCBD), SCHIP children, November 2004
Source for Indiana Data: Hoosier Healthwise Member Survey Results, March 2004

- Timeliness of Health Care Service. Respondents also seemed generally pleased with timeliness of the service they received. Members of Hoosier Healthwise PCCM were asked such questions as how often they received help from calls placed during office hours, how often they were admitted to exam rooms within 15 minutes of appointment, how often they received care as soon as they wanted, and how often office staff was as helpful as the member thought they should be. For three of the four above questions, over 90% of respondents stated "always" or "usually". Only 65% of respondents stated they were always or usually taken to the examining room within 15 minutes of their appointment (See Exhibit V.2). The response rate for CHIP members was generally at or around the total overall average response rate. When compared to national response to these same questions, Healthwise PCCM members had higher percentages of "always" or "usually" response.

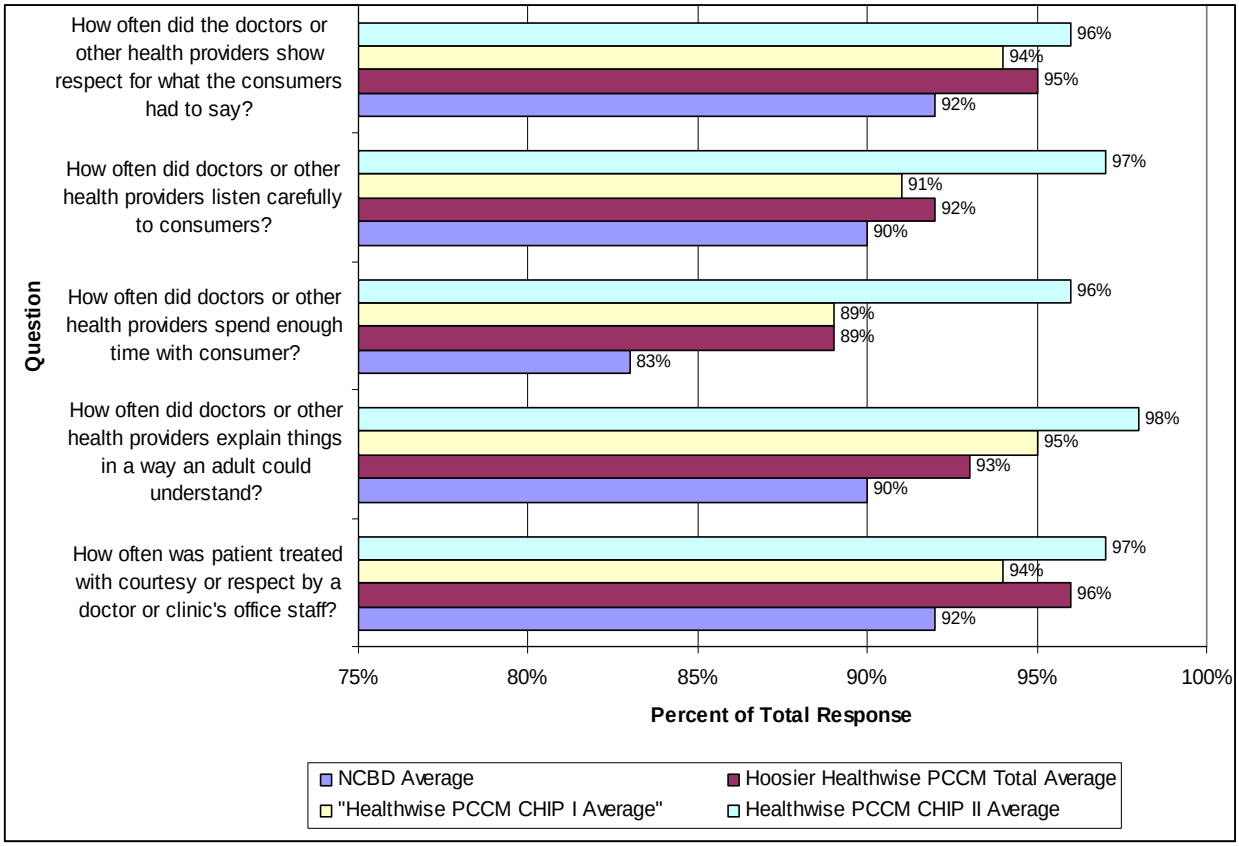
Exhibit V.2
Members' Response to Timeliness in Service Questions
Percentage of Respondents who Stated "Always" or "Usually"



Source for National Data: National CAHPS Benchmarking Database (NCBD), SCHIP children, November 2004
Source for Indiana Data: Hoosier Healthwise Member Survey Results, March 2004

- Courtesy in Health Care Service. In regard to questions of the courtesy of doctors, health care providers and office staff, Healthwise PCCM members generally reported respectful and courteous encounters. Respondents were asked how often they were listened to, how they were respected, how much attention they received, how they were communicated with, and how often they were treated with respect from the office or clinic staff. In four of the five above questions, members responded "always" or "usually" over 90% of the time. CHIP phase I members tended to have lower percentages than the overall average, and CHIP phase II members tended to have higher percentages than the average. When compared to national response to the same questions, Healthwise PCCM members stated higher percentages of "always" or "usually" responses, indicating the average Healthwise member more often receives courteous service than the overall average member of a Children's Medicaid program.

Exhibit V.3
Members' Response to Courtesy in Service Questions
Percentage of Members' who Responded "Always" or "Usually"



Source for National Data: National CAHPS Benchmarking Database (NCBD), SCHIP children, November 2004
Source for Indiana Data: Hoosier Healthwise Member Survey Results, March 2004

Results from Child Enrollees in Hoosier Healthwise Programs by Health Plan

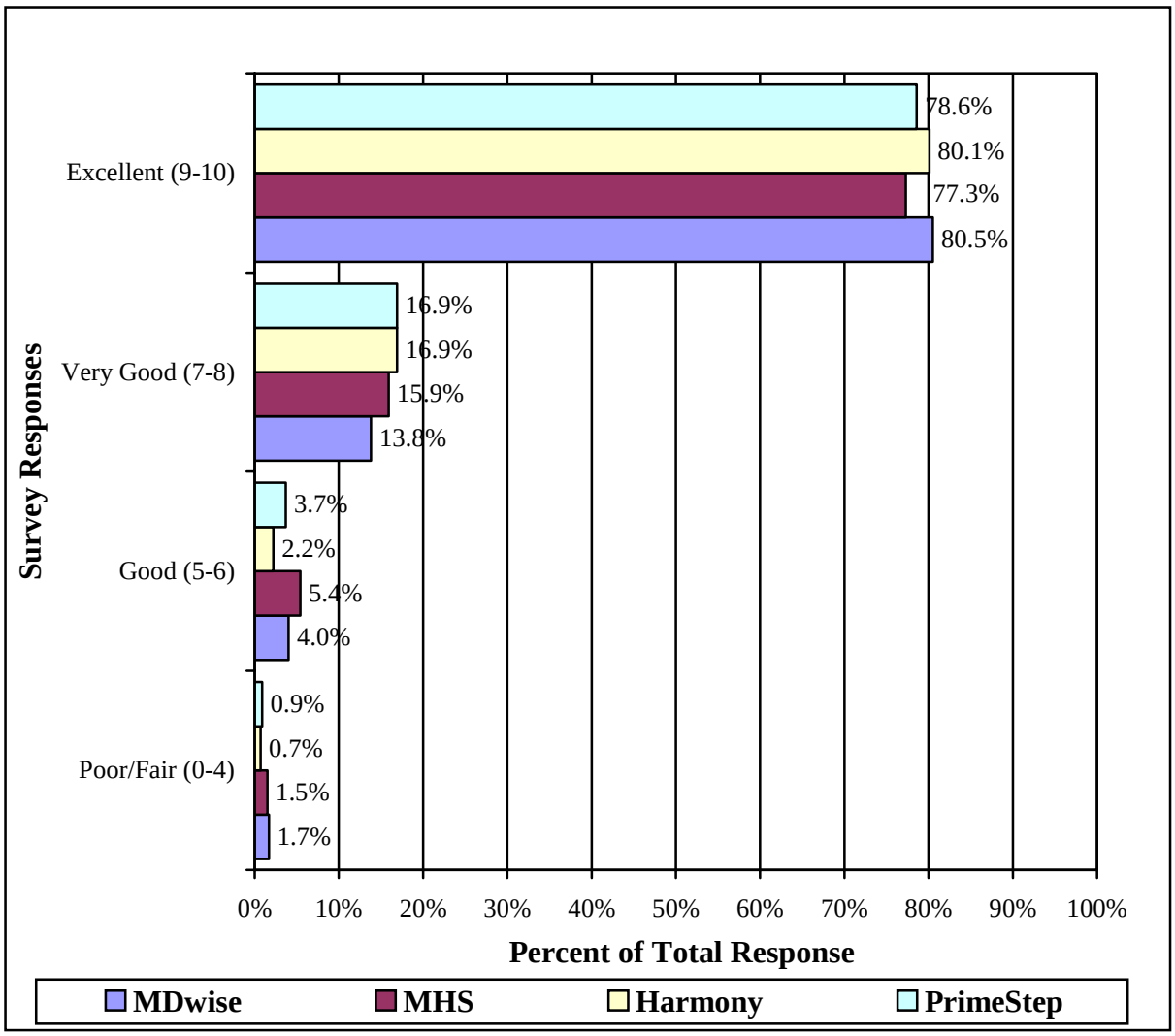
Navigant Consulting summarized the results of the member surveys conducted by Market Measurement for PrimeStep (the PCCM program) as well as those conducted by the three MCOs participating in Hoosier Healthwise in 2004—Managed Health Services, Harmony Health Plan and MDWise. Specific questions were compared from the child surveys conducted by each entity, and the results of these are compared on the following pages. It should be noted that the MCOs did not ask questions specifically to parents of children enrolled in CHIP. Therefore, the comparisons of results in Exhibits V.4 – V.7 are a comparison across health plans and the PCCM program for all children enrolled in Hoosier Healthwise.

Rating of Child's Health Plan

Question: *What number would you use to rate your child's health plan (Excellent = 9-10; Very Good = 7-8; Good = 5-6; Fair/Poor = 0-4)?*

Finding: More than 90 percent of respondents in each health plan gave their child's health plan a rating of very good or excellent.

Exhibit V.4
Response to Rating of Child's Health Plan



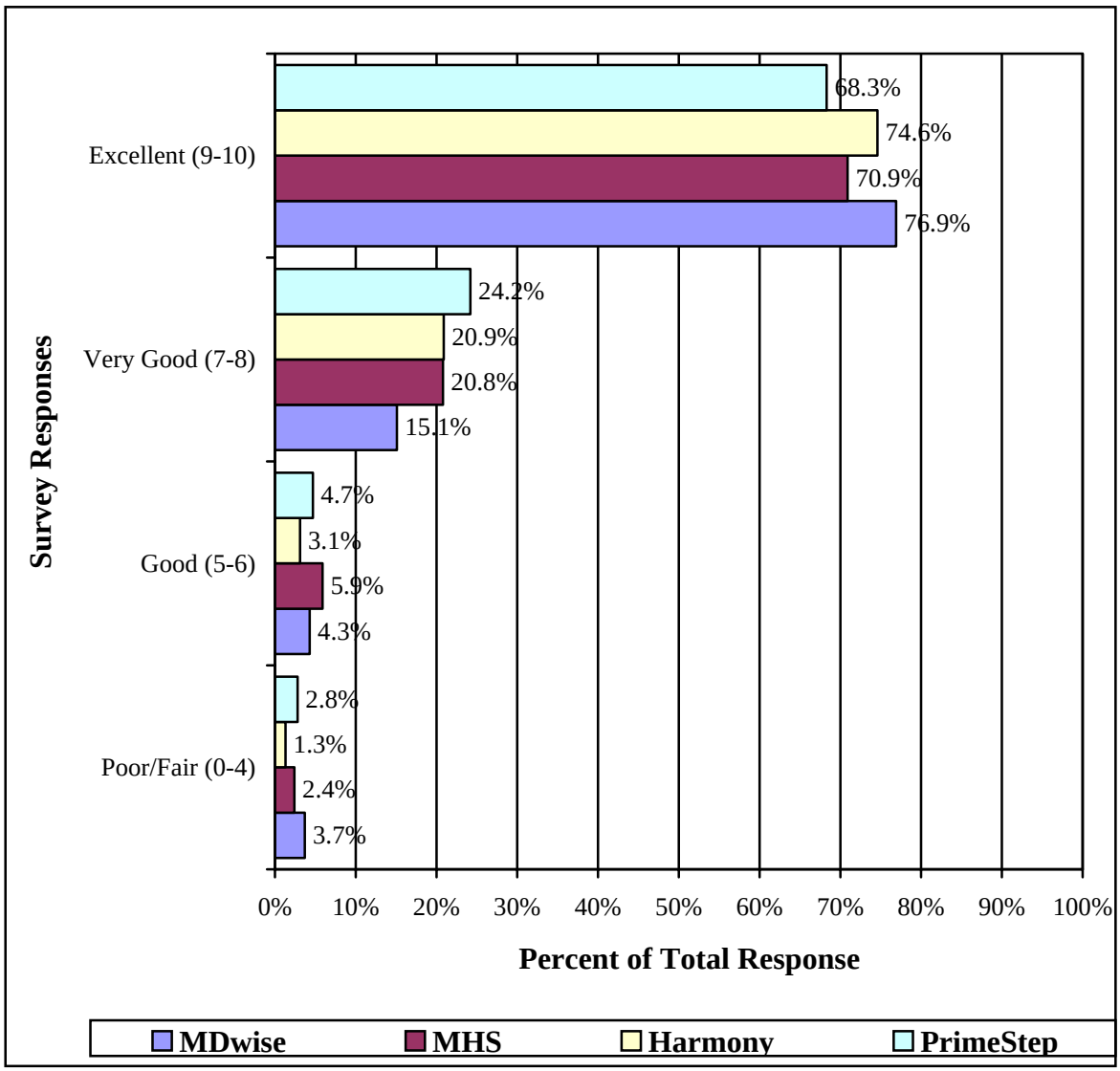
Source: Navigant Consulting's Hoosier Healthwise 2004 Member Satisfaction Survey Report, August 2004

Rating of Child's Personal Doctor

Question: *What number would you use to rate your child's personal doctor (Excellent = 9-10; Very Good = 7-8; Good = 5-6; Fair/Poor = 0-4)?*

Finding: More than 90 percent of respondents for each health plan gave their child's personal doctor a rating of very good or excellent.

Exhibit V.5
Rating of Child's Personal Doctor



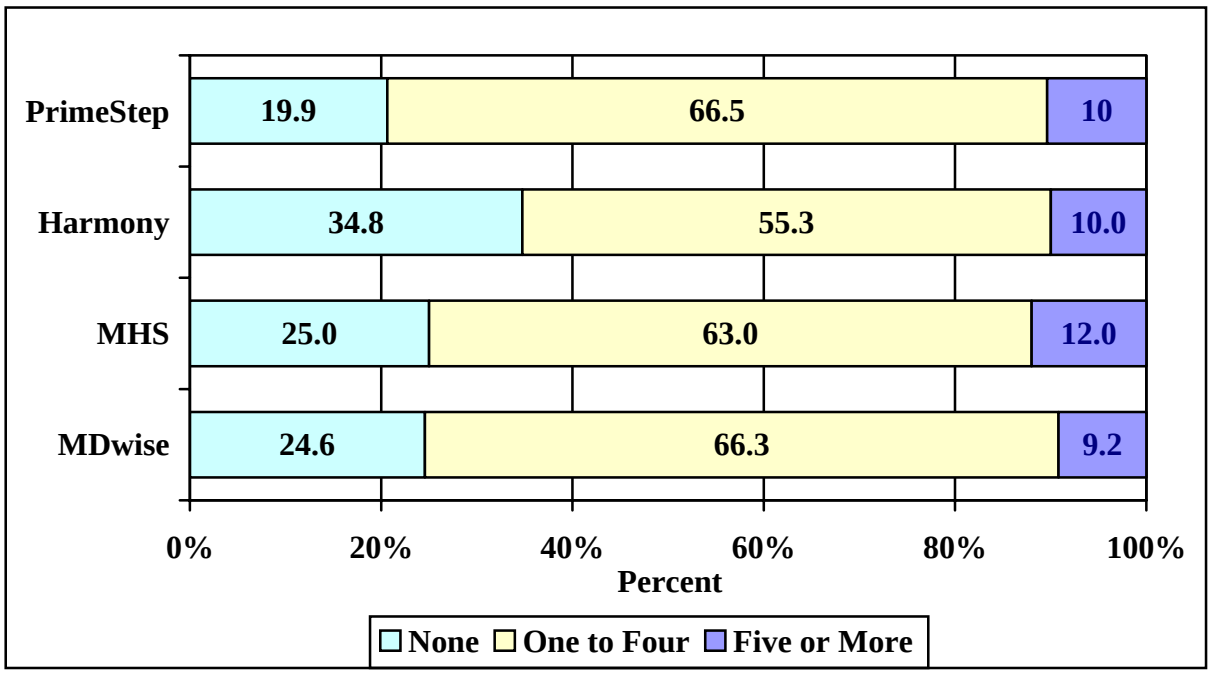
Source: Navigant Consulting's Hoosier Healthwise 2004 Member Satisfaction Survey Report, August 2004

Number of Doctor's Visits for Child

Question: *In the last six months, (not counting the times you went to the emergency room) how many times did you go to a doctor's office or clinic to get care for your child?*

Finding: For all but Harmony Health Plan, at least three-quarters of all children had at least one visit to the doctor or a clinic in the last six months.

Exhibit V.6
Number of Doctor's Visits for Child



Source: Navigant Consulting's Hoosier Healthwise 2004 Member Satisfaction Survey Report, August 2004

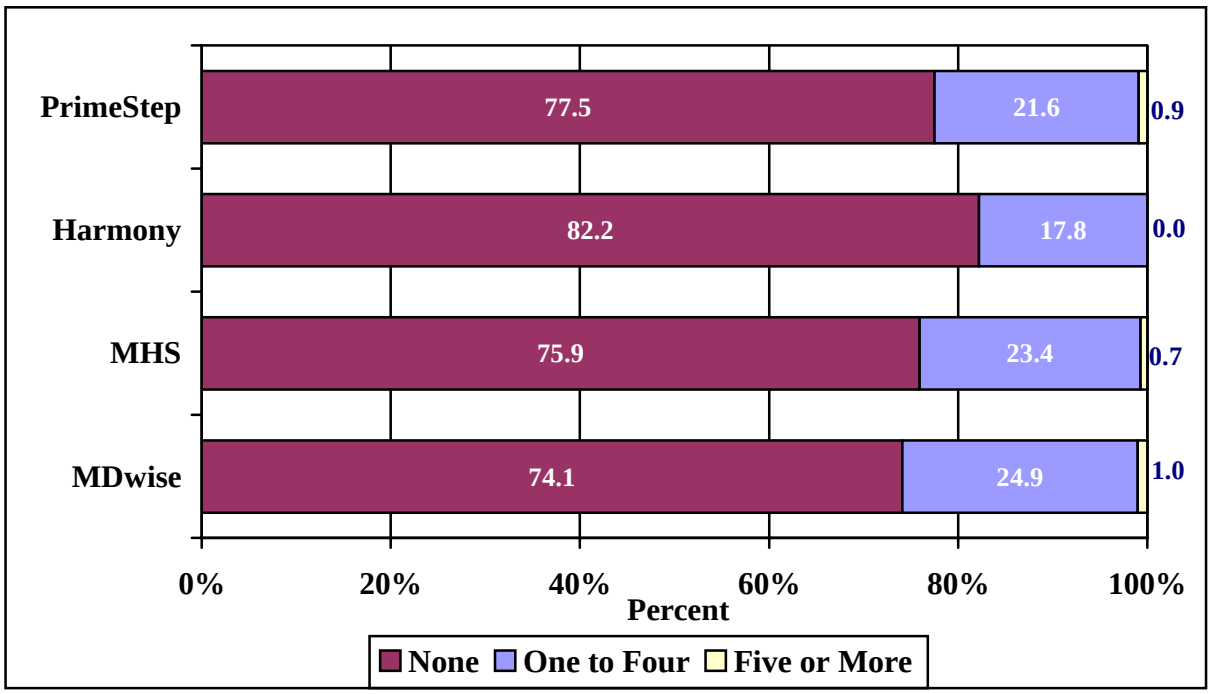
Number of Emergency Room Visits

Question: In *the last six months, how many times did your child go to an emergency room?*

Finding: Approximately 20% of the parents responded that they had taken their child to the ER at least once in the last six months. High rates of emergency room visits may be an indicator that children are not receiving needed preventive care. Therefore, for this measure a high percentage of respondents indicating "no ER visits" is preferred. There will, of course, always be some percentage of children with ER visits for legitimate medical concerns. When this question was asked, there was not a follow-up indicating the type of service received in the emergency room. Therefore, it is unknown whether for those that indicated they had taken their child to the ER it was for emergent or non-emergent reasons. As a result, the percentage reporting an ER visit has a combination of the two and it cannot be determined how many of these visits could be redirected to a primary care setting.

That said, a very small percentage of members reported taking their child to the emergency room five or more times. This population could be one that is using the ER as their primary location to receive care. However, the low percentage in this group may be indicative of legitimate ER visits.

Exhibit V.7
Emergency Room Visits for Child



Source: Navigant Consulting's Hoosier Healthwise 2004 Member Satisfaction Survey Report, August 2004

PMP Satisfaction Survey

The 2004 primary medical providers (PMP) survey conducted by OMPP was mailed to all PMPs participating in the Hoosier Healthwise program in 2003. The response rate was 36% (806), which is slightly lower than last year's response rate of 39%.

The number of PMPs that are at least somewhat satisfied with the Hoosier Healthwise program declined slightly from 67% (2003 survey) to 63% (2004 survey). Of those who responded to the 2004 survey,

- 11% were very satisfied and 52% were somewhat satisfied with the Hoosier Healthwise program
- 37% were at least somewhat dissatisfied

These satisfaction results represent a slight decline regarding satisfaction and a slight increase regarding dissatisfaction from last year's survey. The results are consistent across practice types (e.g. family practitioners, pediatricians, OB/GYNs, etc.), practice profile (e.g. solo practitioner vs. group practitioner), and geographic location.

The areas with the highest rates of satisfaction among PMPs include ease of enrolling in the network, the program provider updates and the ease of verifying patient eligibility. Similar to the previous two years, auto-assignment and reimbursement rates continue to be characterized by widespread PMP dissatisfaction. However, the percent of PMPs dissatisfied with the auto-assignment process decreased from last year's rate of 60% to 58%, while the rate of dissatisfaction with reimbursement rates increased from 61% to 64%.

In addition, PMP satisfaction was found to be particularly low when considering the preferred drug lists of the networks. For example, only slightly more than one-in-ten (12%) provided a rating of either "1" (excellent) or "2". Conversely, about two-thirds (64%) gave a rating of no better than "4" or "5" (poor).

In addition, there has been an increasing trend among PMPs who report having "too many" Hoosier Healthwise patients. In 2004, 26% of PMPs reported having a high patient load. This is up slightly from last year's rating, where 25% of PMPs reported having too many Hoosier Healthwise patients. If these trends continue, the state may encounter access problems due to lack of provider participation.

A high proportion of Hoosier Healthwise providers were critical of the auto-assignment rates (31%) and the level of communication (24%) within the program. More specifically, PMPs were most critical of the auto-assignment criteria "patients who are dismissed from your practice and later reassigned to you" (i.e., 66% at least "somewhat dissatisfied") and "time required for PMP changes" (63% at least "somewhat dissatisfied)."

HEDIS Measurements

In 2004, the OMPP collected 2003 data from each of the managed care entities participating in Hoosier Healthwise that tabulated measurements of 28 of the indicators defined by the Health Plan Employer Data Information Set (HEDIS[1]). These measures are intended to track the effectiveness of care, access/availability of care, and the use of services and to measure managed care plan performance. Over 35 states use at least some of the HEDIS to measure quality in their Medicaid programs. Indiana has been collecting HEDIS measures since 2001. The National Committee for Quality Assurance (NCQA) developed the HEDIS and collects data from states to formulate national median values for the Medicaid population. States can compare their measures to HEDIS definitions to ensure the results are comparable.

Navigant Consulting summarized the HEDIS measurements reported by each of the Hoosier Healthwise managed care entities, including:

- Harmony Health Plan of Indiana
- MDwise
- Managed Health Services (MHS)
- Prime*Step* (the PCCM program)

To ensure the validity of the data collection and reporting, Harmony, MHS and Prime*Step* used certified HEDIS software vendors to collect the data. Although MDWise did not use one of these vendors, all of the MCOs were subject to a HEDIS audit to ensure proper data collection.

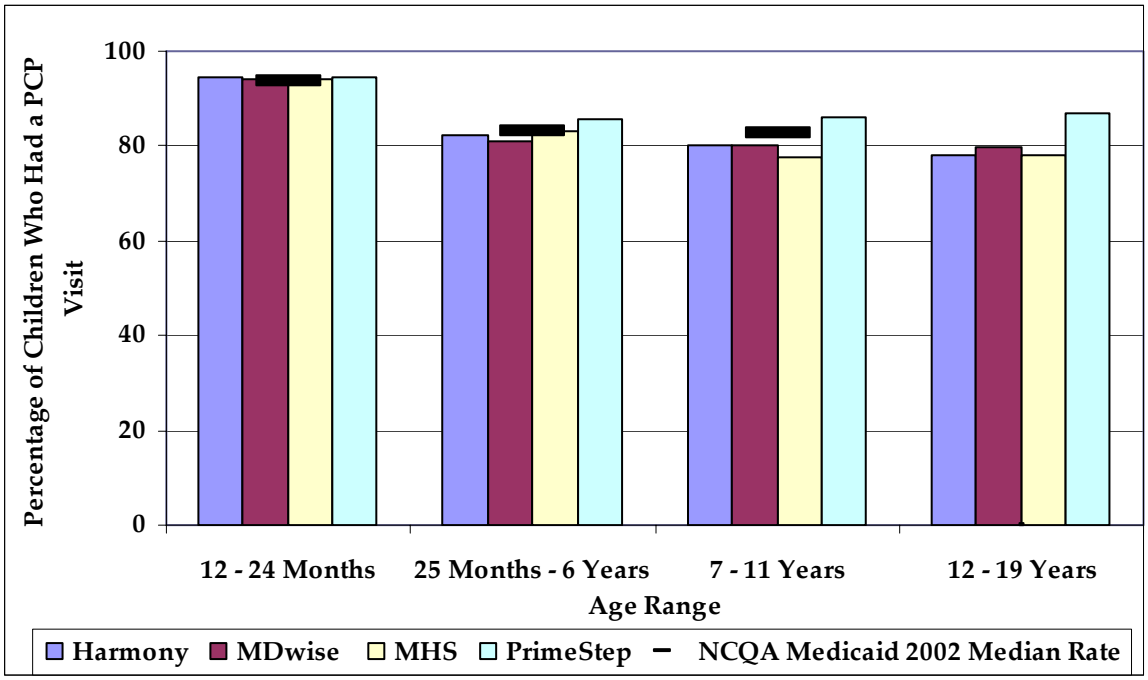
The HEDIS measures were summarized in a briefing paper presented to the OMPP in September 2004. In addition to being able to compare the results across the managed care entities, the national median values provided by HEDIS were also shown to compare how Indiana managed care compares to national managed care plans.

Many of the HEDIS indicators are specific to children. The next section reviews the findings reported by each managed care entity, how they compare to each other, and how they compare to the national benchmark. It should be noted that these results are for all children in Hoosier Healthwise, not CHIP children specifically.

Seven HEDIS measures addressing key health care issues concerning children and adolescents are presented on the following pages. The 2002 NCQA median rates (50th percentile) for Medicaid managed care are also shown. It is important to note that the NCQA data is an unweighted rate across health plans. Thus, health plans with large and small numbers of members count equally in the NCQA data. In many cases, the NCQA median rate is not necessarily the benchmark used by Hoosier Healthwise. However, it is helpful to understand how Indiana's Medicaid managed care plans compare to similar plans nationally.

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

Exhibit V.8
Children's Access to Primary Care Practitioners (PCPs)



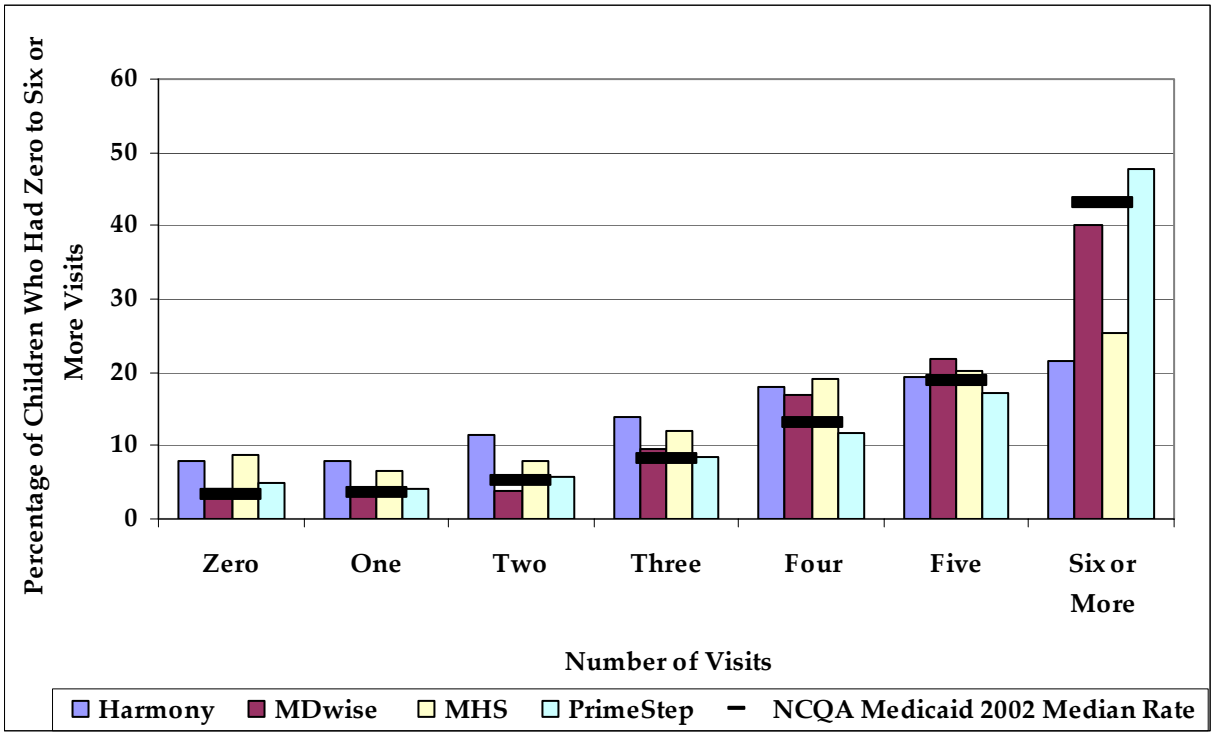
Source: Navigant Consulting's Hoosier Healthwise HEDIS 2004 findings, September 2004

Exhibit V.8 shows that each of the MCEs achieved at least the NCQA Medicaid median rate for children's access to primary care practitioners (PCPs). [Note that NCQA does not provide a national median for PCP access for the 12-19 year age group.] Due to recommended immunizations at certain age levels, the percentage of children with a PCP visit will vary by age group. However, it is encouraging that all three MCOs and Prime*Step* reported that 80% or more of children in the study across all age groups had at least one PCP visit during 2003.

For children in the 12-24 months and 25 months-6 years groups, the children studied were those that were continuously enrolled in 2003 and the percentage reflects those that had a PCP visit during 2003.

For children in the 7-11 years and 12-19 years groups, the children studied were those that were continuously enrolled in 2002 and 2003 and the percentage reflects those that had a PCP visit during either 2002 or 2003.

Exhibit V.9
Well-Child Visits in the First 15 Months of Life

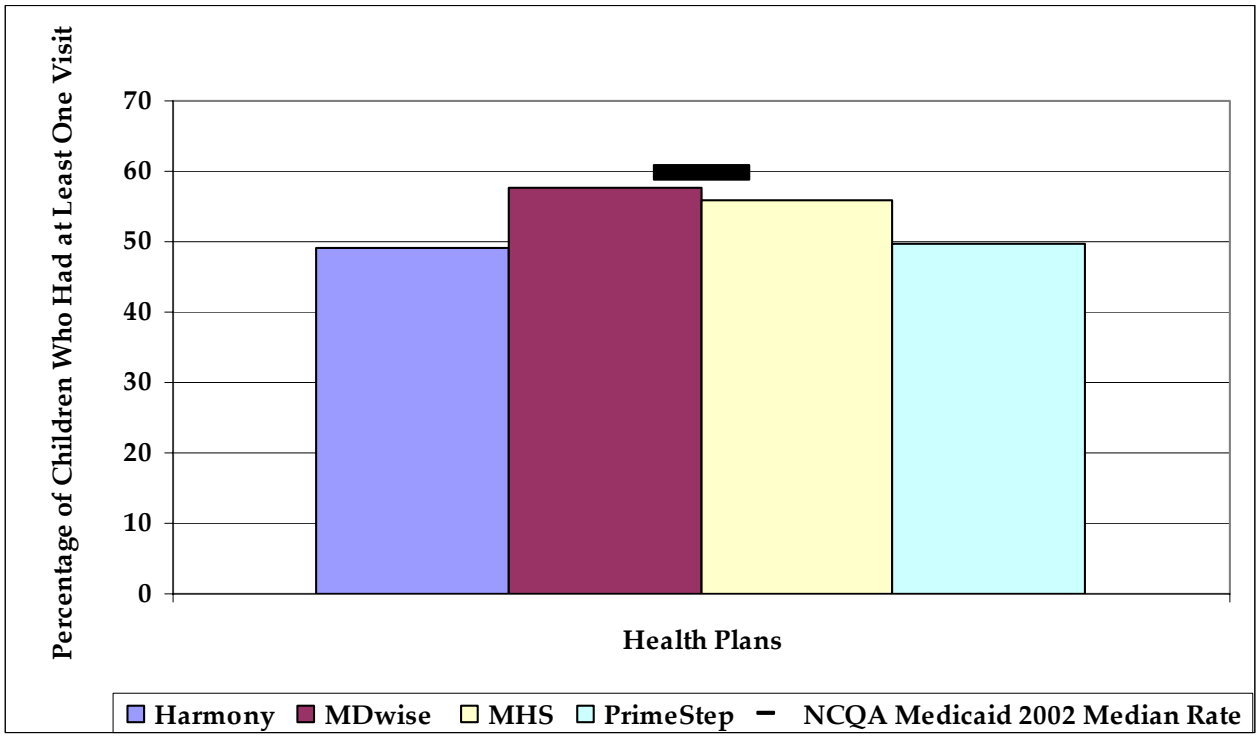


Source: Navigant Consulting's Hoosier Healthwise HEDIS 2004 findings, September 2004

Exhibit V.9 reports on those children that turned 15 months old during 2003 and have been continuously enrolled in Hoosier Healthwise since at least 31 days of age. The findings for Indiana's Medicaid health plans are very similar to those reported nationally for the number of well-child visits and there is relative consistency between the health plans as well on this measurement. All health plans aim to have every child receive at least one well-child visit, if not more, during this age. The rate of children with no well-child visits was slightly higher for Harmony and MHS. The only other area where Indiana's plans differ from the national median is for the indicator of six or more visits during the year.

It should be noted that this particular child indicator is more relevant to the Medicaid portion of Hoosier Healthwise than the CHIP portion as the vast majority of children in this age group are enrolled in Medicaid and not in CHIP.

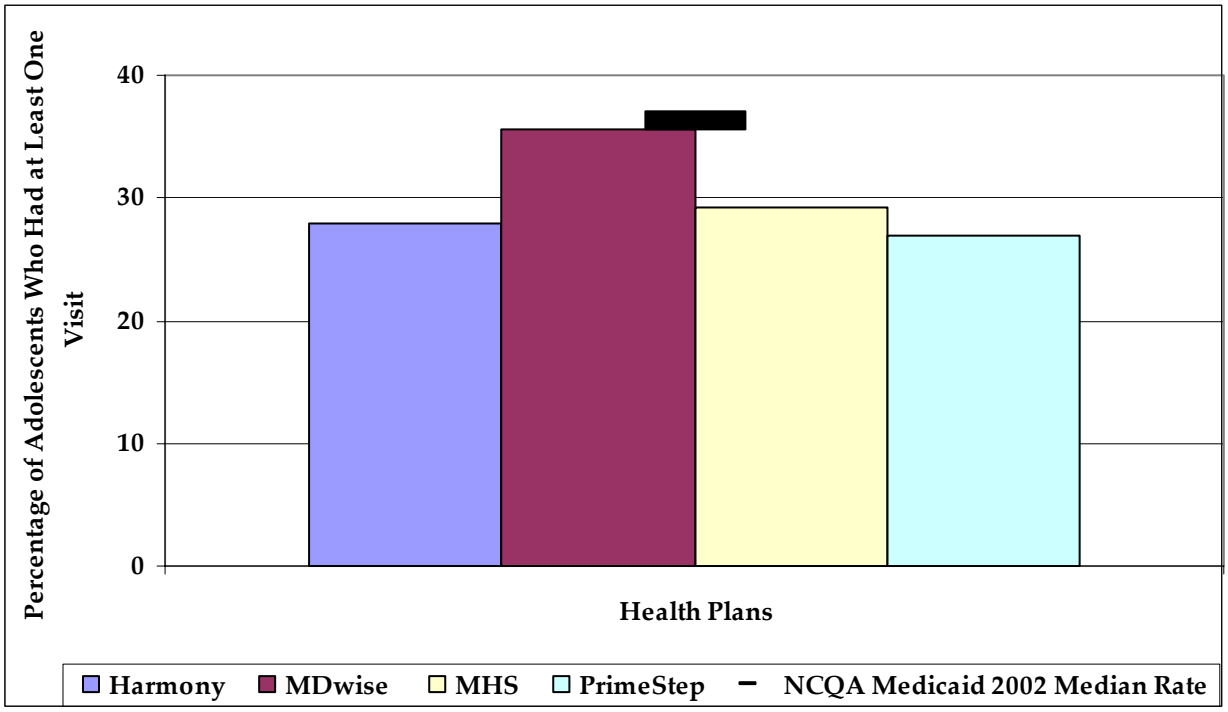
Exhibit V.10
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life



Source: Navigant Consulting's Hoosier Healthwise HEDIS 2004 findings, September 2004

Exhibit V.10 examines the children ages two through five who were continuously enrolled in Hoosier Healthwise in 2003 and had at least one visit with a PMP during the year. The findings show some slight variation between the health plans on this measurement, but all Indiana plans are slightly below the NCQA national median for Medicaid health plans of 60%.

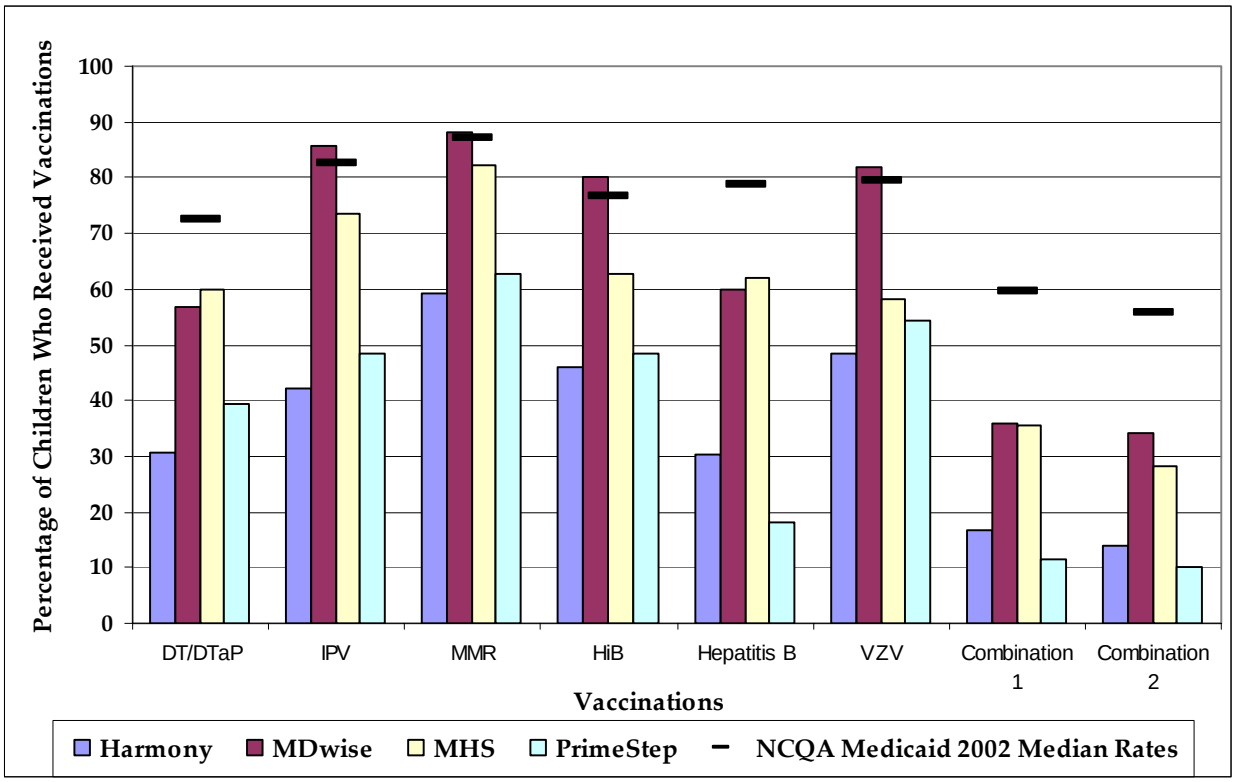
Exhibit V.11
Adolescent Well-Care Visits



Source: Navigant Consulting's Hoosier Healthwise HEDIS 2004 findings, September 2004

Exhibit V.11 measures the same indicator of the percentage of members with a well-child visit, but for adolescents (defined as members aged 12 through 21). Members reviewed were those who were continuously enrolled in Hoosier Healthwise in 2003 and had at least one visit with a PMP during the year (which could also include an OB/GYN for females). The findings show some slight variation once again between the health plans on this measurement, but all Indiana plans except MDWise are below the NCQA national median for Medicaid health plans of 35%.

Exhibit V.12
Childhood Immunization Status

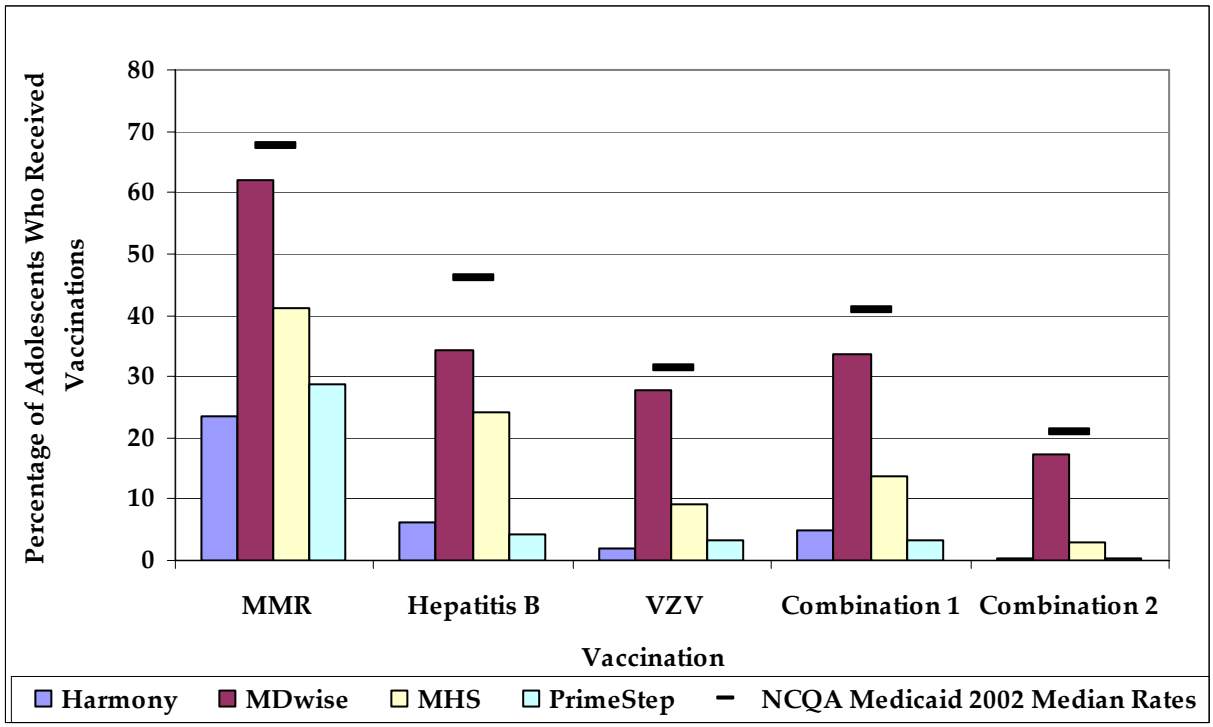


Source: Navigant Consulting's Hoosier Healthwise HEDIS 2004 findings, September 2004

Exhibit V.12 presents immunization rates for a number of immunizations recommended for children including diphtheria/pertussis/tetanus (DT/DTaP), polio (IPV), mumps/measles/rubella (MMR), hemophilus influenza type B (HiB), hepatitis B, and chicken pox (VZV). Children may receive these immunizations separately or in a combination (Combination 1 excludes chicken pox and Combination 2 includes chicken pox).

Children studied were those that turned age two during 2003 and had been enrolled in the health plan for at least the 12 months prior to turning this age. With the exception of MDWise, most of Indiana's health plans could improve the rate of immunizations for their young enrollees. EP&P conducted an analysis for a similar time period (SFY 2003 and SFY 2004) to identify if there were large differences in immunization rates between children in CHIP and Medicaid. We found results similar to those reported by the health plans in Exhibit V.12 and did not find a meaningful difference in immunization rates between CHIP and Medicaid children in this age group. There is a limitation to this finding. Many immunizations are conducted through the Department of Health, not Medicaid. Only recently has there been an immunization registry whereby vaccinations for Hoosier Healthwise children could be collected from the Department of Health. To the extent that the registry is incomplete, the findings on this exhibit may be underreported.

Exhibit V.13
Adolescent Immunization Status



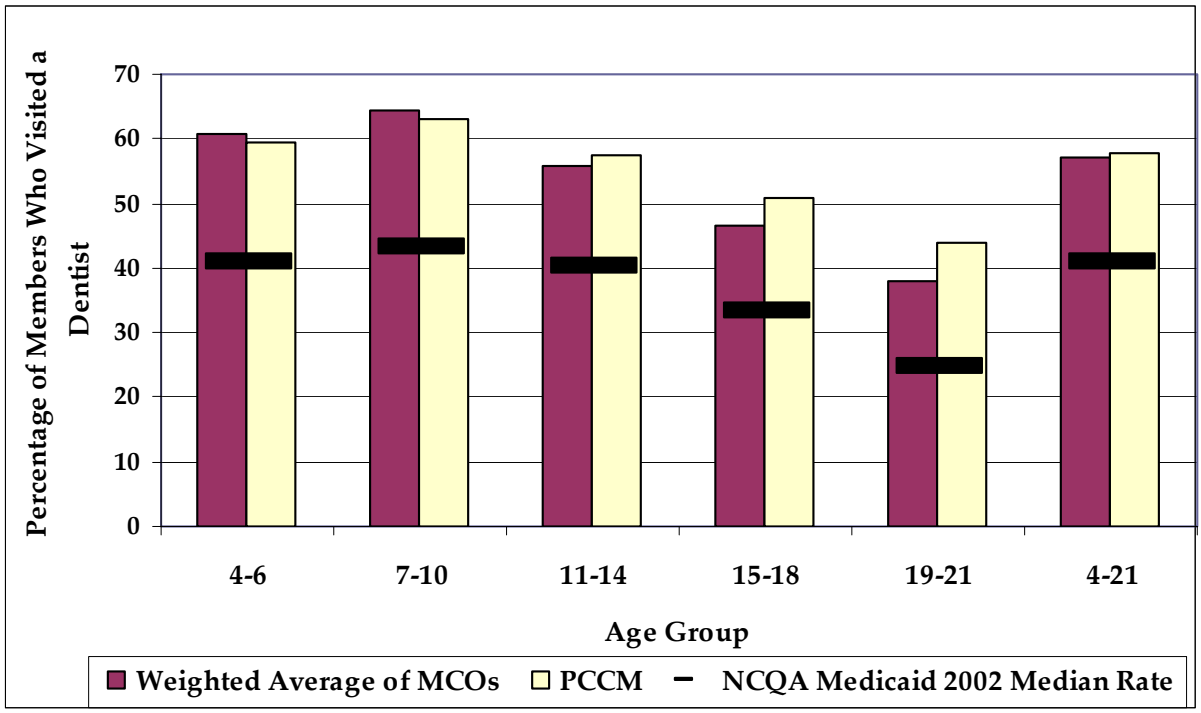
Source: Navigant Consulting's Hoosier Healthwise HEDIS 2004 findings, September 2004

Immunizations are also recommended later in a child's life by the time they reach 13 years old. The children reported on in Exhibit V.13 are the percentage of children who turned 13 years old in 2003 and were enrolled in their Hoosier Healthwise health plan for the 12 months prior to turning 13. Similar to the administration of immunizations to young children, teenagers may receive immunizations separately for measles/mumps/rubella, hepatitis B, and chicken pox or as a combination.

The findings shown above are similar to those found for the younger children. The MDWise plan has the highest vaccination rates among the health plans and is close to the NCQA Medicaid median values. The other health plans tend to have lower vaccination rates than MDWise and their peers nationally.

The findings here may also be underreported due to limited data exchanges on vaccinations between Medicaid and the Department of Health.

Exhibit V.14
Annual Dental Visit



Source: Navigant Consulting's Hoosier Healthwise HEDIS 2004 findings, September 2004

An area where Indiana children have continually had higher utilization than national trends is related to dental services. Exhibit V.14 shows how Indiana Hoosier Healthwise utilization compares with the NCQA national median. The population studied was Hoosier Healthwise children who were continuously enrolled in 2003 and had at least one dental visit during the time period. For all age groups, the children in both RBMC and PCCM exceeded the NCQA median, often quite higher. In this exhibit, the MCOs are shown as a weighted average. The data was not reported by the MCOs individually because the MCOs do not deliver this service. It is carved out of the monthly capitation rate they receive for children. Therefore, the weighted average of MCOs relates to the children enrolled in RBMC who receive dental services on a fee-for-service basis. There is also little difference by age group between dental utilization for the RBMC and PCCM enrollees.

Helpline Statistics

This section examines the amount and type of calls made to both the Hoosier Healthwise Helpline for members as well as the helpline set up for providers. Helpline calls are tracked and categorized by issue codes on a month-by-month basis. Similar to what we found in 2003, the majority of calls to the Helpline in 2004 by members were for recipient eligibility inquiries. For providers, the majority of calls were related to administrative authorization overrides. However, Hoosier Healthwise members and providers do call the Helpline to report quality-related issues and concerns. Thus, there is an opportunity to review separately the frequency of those calls as a percent of total calls received.

Overall, the volume of calls varied over the year. The number of calls to the Helpline by members increased by approximately 8,000 calls from last year's total. The largest number of calls received by the Helpline by members was received in the latter part of the year (post-June). This is similar to 2002, but differs from last year where the majority of calls were received in the first part of the year. The number of calls by month in 2004 ranged from a low of 6,793 in February to a high of 10,135 in August. Differences in when the volume of calls were received by month in each of the last three years may be due in part to when some counties moved to mandatory managed care and members may have had questions pertaining to this move.

The number of calls received by the Helpline for providers, on the other hand, was equally distributed for the most part throughout the year. The number of calls ranged from a low of 269 in June to a high of 717 in November.

Similar to last year, member calls regarding quality issues represented a very small percentage of calls to the Helpline in 2004. There was a small decline from 2003 where quality-related calls to the Helpline were 3% of the total call volume compared to 2% of the calls in 2004. As the total call volume fluctuated over the year for each month, the quality-related calls remained relatively constant.

The following is a list of all quality-related issues that members reported in 2004:

- Appointment Delay
- Inconvenient Location
- Insufficient After-Hours Coverage
- MCO Ancillary Service Access Issues
- Network Limitations
- Physician/Patient Relationship Unacceptable
- Quality of Service Issues
- Transportation Problems
- Treatment by Staff
- Unable to Obtain a Referral
- Unsatisfactory Communication
- Unsatisfactory Quality of Care

- Untimely Communication
- Waiting Time

"Inconvenient Location" and "Unsatisfactory Quality of Care" were the two most frequent quality-related reasons members called the Helpline in 2004. This followed the same pattern as last year. In addition, the percentage of total quality calls that were attributed to "Unsatisfactory Quality of Care" decreased from 26.1% in 2003 to 20.1% in 2004. Notably, "Unable to Obtain a Referral" came in at a close third with 369 calls to the Helpline. See Exhibit V.15 below.

Exhibit V.15
Total Volume and Percent of Quality-Related Calls for 2004
From Hoosier Healthwise Members

	Total Calls	Total Quality-Related Calls	Unsatisfactory Quality of Care	Inconvenient Location
Total Number of Calls	100,664	1,900	382	669
Percent of Total Calls		1.9%	0.4%	0.7%
Percent of Total Quality Calls		100%	20%	35%

Source: AmeriChoice, Member Issues – Helpline Only, 2004

With regard to Hoosier Healthwise providers, many providers expressed the same issues and concerns as the Hoosier Healthwise members in their calls to the Helpline. However, the Hoosier Healthwise providers also made calls regarding administrative concerns, such as payment and prior authorization. The following is a list of all quality-related issues that providers reported in 2004:

- Abusive/Hostile Member
- Appointment Delays
- Cannot Get a Referral
- Language Barriers
- Missed Appointments
- Misuse of Emergency Room
- Panel Full
- Physician/Patient Relationship Unacceptable

Unlike the member Helpline statistics, provider calls regarding quality issues represented a significant percentage of calls to the Helpline in 2004. However, the volume of provider calls overall was only 6% of the total volume of member calls. For each of the quality issues cited above, the frequency of calls remained relatively constant. The two most frequent quality-related reasons for provider calls to the Helpline were "Physician/Patient Relationship Unacceptable" and "Missed Appointments". See Exhibit V.16 on the next page.

Exhibit V.16
Total Volume and Percent of Quality-Related Calls for 2004
From Hoosier Healthwise Providers

	Total Calls	Total Quality-Related Calls	Physician/Patient Relationship Unacceptable	Missed Appointments
Total Number of Calls	6,492	1,105	172	693
Percent of Total Calls		17.0%	2.6%	10.7%
Percent of Total Quality Calls		100%	16%	63%

Source: AmeriChoice, Provider Issues – Helpline Only, 2004

Quality Improvement Committee Monthly Meeting Minutes for 2004

Quality Improvement Committee (QIC) meetings are scheduled on a monthly basis to review issues that impact multiple stakeholders in the quality review process of the Hoosier Healthwise program. As such, the QIC meetings usually have at least one representative from each of the following parties in attendance:

- Each of the managed care organizations (MCOs)
- AmeriChoice, the administrator of Prime*Step*, the PCCM program
- Navigant Consulting (the monitoring contractor for Hoosier Healthwise)
- Office of Medicaid Policy and Planning (OMPP)

Depending on the agenda topics, some meetings also included representatives from the CHIP program, various Hoosier Healthwise contractors and additional guest speakers. A review of the minutes from the 2004 QIC meetings demonstrate that the committee continues to address some of the issues from 2003 and is actively identifying and highlighting areas that may need improvement. These are discussed in detail below.

Shadow Claims Improvement Project

As noted in the 2004 CHIP annual report, shadow claims reporting is an ongoing issue for the Hoosier Healthwise program. These are the claims reported by MCOs to the State that are used for tracking utilization as well as assisting in the development of capitation payments made to the MCOs. The QIC decided to make shadow claims reporting a standing agenda item in 2003 and this continued in 2004.

During 2004, there were several phases of the MCO shadow claims improvement project underway. They included:

- MCO Shadow Claim Work Plan – This is a process that has been ongoing from previous years. In 2003, MCOs had to submit a draft workplan to OMPP and update the workplan monthly. The intent of this task is to encourage the MCOs to focus on

their shadow claims process from beginning to end by requiring them to submit a monthly plan documenting their efforts. As such, each MCO submits a plan to Navigant Consulting and OMPP by the first of the month

- Monthly Data Grid – The QIC data grid documents several health care measures within the Hoosier Healthwise program. OMPP is requiring the MCOs to revise the QIC data grid to include an additional shadow claim measure (described further on page V-25).

- Life of a Claim Study – This is an ongoing study conducted for OMPP by Navigant Consulting. The intent of this study is to be sure that the shadow claims submitted by the MCOs to EDS (the State's fiscal agent) are treated appropriately by the EDS system. The first round of the study was completed in 2004 and the second round is underway. The study will track shadow claim submissions from each MCO to EDS for a one-month period and ensure that shadow claims are being assigned to the correct MCO by EDS.

In addition, during each monthly QIC meeting, each MCO provided an update on its shadow claims workplan. Each of the MCOs approached the workplan differently and focused on those areas that have presented problems for them. For example, one MCO is focusing on pharmacy claims in an effort to understand why so many claims were not passing the State's electronic edit processes, and therefore were considered "rejected". As a result of the shadow claims project, this MCO discovered that the vast majority of rejections were due to miscoding.

Another MCO expanded its focus from Primary Medical Provider (PMP) claims to also include inpatient hospital claims in two regions within the state. In addition, the MCO is working with its Provider Relations staff to determine which providers to target for educational opportunities and to determine the best methodology for providing the education.

MCO Reporting Manual

In February 2004, Navigant Consulting distributed a copy of the 2004 MCO Reporting Manual to each MCO. The new manual is comprehensive and includes instructions for most reporting requirements. In addition to the manual, Navigant Consulting provided each MCO with a reporting calendar and an edit document containing the changes from the 2003 manual.

Changes to the reporting process were summarized:

- Quarterly reports are due at the end of the month
- OMPP is requiring that plans report their 2004 Top Ten Claims Denial separately for hospital, physician, and pharmacy claims
- In 2004, the plans' claims adjudication rates would be reflected in non-financial reporting for hospital, physician, and pharmacy claims separately

Emergency Room Performance Improvement Project

This project was designed to develop strategies to move Hoosier Healthwise membership into more appropriate (e.g. emergent or life-threatening) use of emergency room (ER) services. OMPP kicked off this project in July 2004. The objective of the project is to:

- Identify best practices in managing the Hoosier Healthwise members' ER utilization
- Identify ways to effectively educate members, ER providers and PMPs about managed care practices
- Provide OMPP insights to address community concerns regarding ER utilization and reimbursement practices within the Hoosier Healthwise program

During the October 2004 QIC meeting, the committee reviewed general ER utilization data. Navigant Consulting distributed summary results of utilization data. In addition, Navigant identified the common issues among Hoosier Healthwise members who are high utilizers of the ER. Subsequently, each MCO identified the methods used to reduce inappropriate ER visits.

One MCO stated that it conducts internal investigations of high ER utilization, reviews pharmacy utilization for those members, and found that those members had repetitive drug-seeking behaviors. As part of its operations, the MCO refers all members to case management who have three or more ER visits in the previous nine months. However, the use of case management appeared to not have an impact on ER use.

Another MCO is revising its member and provider outreach process to facilitate enrolling members who are high ER utilizers into case management programs. The MCO reviews cases for high ER utilizers every three months. In addition, they are educating PMPs to refer members with frequent visits to the ER due to significant pain (e.g., back pain, abdominal pain, etc.) to pain management clinics or investigate for sources of pain.

The third MCO participating in Hoosier Healthwise in 2004 reported that many of the high ER utilizers in its sample submitted to Navigant were admitted to the hospital. Similar to the first MCO, this MCO identified some drug-seeking behavior among these members.

QIC Data Grid

The QIC Data Grid is a tool that the committee uses to track various program areas for each of the MCOs. Each MCO reports data for the program areas and the QIC reviews that data to gain insight into issues surrounding the Hoosier Healthwise program. Particularly, the QIC monitors trends within the program areas with the anticipation that the data would provide OMPP and other Hoosier Healthwise partners an advanced opportunity to resolve or at least address the outstanding issue. Some of the areas covered by the grid are:

- Member inquiries
- Grievances and Appeals (Members and Providers)

- Helpline calls/Abandonment rates
- Enrollment

In 2004, as part of the Shadow Claim Improvement Project, OMPP required the MCOs to revise the data grid to include an additional shadow claim measure – encounters/claims received per member per month (by claim type). This will help OMPP ensure that the plans understand the volume of shadow claims the State is getting from each MCO and monitoring for any errant trends. In April, each of the MCOs received the new grid with this new measure.

CHAPTER VI
OVERVIEW OF FINDINGS

Now that the program is in its eighth year, the Indiana CHIP is starting to show signs of maturity. Enrollment has leveled off for CHIP Phase I and, although it still grew 19% in calendar year 2004, the growth in CHIP Phase II was also slower in 2004 than in prior years.

The composition of Indiana's CHIP has also changed since the beginning of the program. Whereas teenagers comprised the highest percentage of enrollees in the initial years, the distribution by age group is looking more like the distribution in the overall Hoosier Healthwise child population, with the exception that few infants are enrolled in CHIP because they are already eligible for Medicaid.

The delivery of services has also changed over the course of the program's history. As more counties in Indiana become mandatory Risk-Based Managed Care (RBMC) counties as well as additional managed care organizations (MCOs) contracting with the State beginning in 2005, so too has the enrollment of children in CHIP migrated from the Primary Care Case Management (PCCM) delivery system to the RBMC delivery system. Because of contractual monitoring requirements imposed on the MCOs, this movement in the population has allowed for a more concerted focus on well-child visits and immunizations for children as well as overall increases in the utilization of primary care visits.

This chapter summarizes the findings discussed throughout this report. This is the fifth annual evaluation of Indiana's CHIP conducted by EP&P Consulting, Inc. (EP&P). As in past years, our evaluation focuses on the most recent data available to identify trends in enrollment, service utilization, payments, access to services/providers, and quality monitoring.

The evaluation includes analyses of enrollment figures and service claims for the period January 2002 to December 2004 to determine if:

- Children enrolled in CHIP Phase II access and utilize services in the same manner as children enrolled in CHIP Phase I and if there have been any changes since prior evaluations

- Children enrolled in CHIP are utilizing services in a manner similar to Medicaid children and if there have been changes since prior evaluations

- There are differences in utilization patterns among the three types of service delivery models within Hoosier Healthwise—the PCCM system, the RBMC system, and the Fee-For-Service (FFS) system

- There are differences in per member per month (PMPM) expenditures between CHIP Phase I, CHIP Phase II and children in Medicaid and, if so, if this is a result of differing utilization patterns, cost of services, or subpopulations by age group

- There are differences in PMPM payments between the RBMC delivery system (paid as a monthly overall amount for all major services) and the PCCM/FFS delivery systems (paid on a claim-by-claim basis as the services are incurred)

- There are differences in utilization and expenditure patterns between age groups to better understand the underlying differences between CHIP and Medicaid

- There are any systematic access or quality issues that have changed between calendar year 2003 and 2004 that would change findings from the annual evaluation report submitted on April 1, 2004.

Available national and state-level data was obtained as comparative benchmarks with which to measure Indiana's CHIP program. The evaluation also included analyses of internal reporting documents provided by the OMPP that focused on monitoring.

This section of the evaluation provides a summary of findings related to the above questions. At the end of the chapter, EP&P Consulting provides recommendations for the CHIP Office in how to continue improving upon the strong base already developed for monitoring the program.

KEY FINDINGS RELATED TO ENROLLMENT

- Indiana's uninsurance rate of 20% for children in families below 200% of the federal poverty level (as measured from 2002 to 2003) is lower than the national average (21%), but slightly higher than the average among neighboring states (from 12% to 20%).

- Enrollment growth in CHIP Phase I has been flat over the past few years, while CHIP Phase II is growing quickly (19% in 2004). This difference is probably the result of the difference in the length of time each portion of the program has been in existence.

- The average age of children in CHIP Phase I (slightly over 10 years) is higher than the average ages of children in either CHIP Phase II (slightly over 8 years) or Medicaid (slightly over 7 years), primarily due to differences in eligibility criteria between the three programs.

- The increasing number of counties where RBMC enrollment is mandatory and the general transition towards managed care led to high growth rates in RBMC enrollment in 2004 and, alternatively, negative growth in the PCCM delivery system.

- The average period of enrollment for members is consistent across programs and age groups at about 10 months, which is slight increase from 2003.

KEY FINDINGS RELATED TO ACCESS

- Though the number of providers increased from 2003 to 2004 and the number of enrollees per provider decreased during the same period, the number of full pediatric panels (that is, the number of pediatricians that would accept no more patients) increased slightly.

- More members in the RBMC delivery system access PMP physician services and dental services than members in the PCCM and FFS delivery systems, but less of the RBMC members access outpatient, non-PMP and pharmacy services than members in the PCCM and FFS systems do.

- Overall, about half of children enrolled in CHIP have used PMP services in both calendar year 2003 and calendar year 2004, regardless of the delivery system. Children are more likely to use these services when they are younger (under age five).

- About 80% of children in the PCCM and FFS delivery systems have seen some type of physician (either one defined as a PMP or one not defined as a PMP) in CY 2003 and CY 2004, while about 70% of children in RBMC delivery system have seen one of these types of providers.

KEY FINDINGS RELATED TO SERVICE UTILIZATION AND PAYMENTS

- CHIP expenditures per member per month are lower than expenditures per member per month for Medicaid children. This is true for children enrolled in both the PCCM/FFS delivery systems as well as those enrolled in the RBMC delivery system. For primary services (general hospital, physician, and pharmacy), CHIP children cost the State about 5% less on average per month than Medicaid children. When other services (including mental health-related services) are included in the comparison, CHIP children cost the State significantly less—about 20% less—on average each month than Medicaid children

- For services provided in both the PCCM/FFS and the RBMC delivery systems, CHIP expenditures per member per month for the RBMC delivery system ($72 PMPM) are $9 less than per member per month expenditures for the same services delivered to the PCCM and FFS populations ($81 PMPM).

- The distribution of expenditures across categories of service for the PCCM and FFS populations in CHIP have not changed significantly between SFY 2003 and SFY

2004. Pharmacy expenditures have increased at a higher pace than other service categories.

- Indiana has a similar distribution of CHIP expenditures among major services (hospital, physician, pharmacy, and dental) as compared to other states' CHIP programs in its region.

- When measured on a claims per 1,000 enrollees level, children in the RBMC delivery system of CHIP have higher utilization rates for primary medical visits and dental services than children in PCCM and FFS delivery systems, but lower rates of utilization for hospital and pharmacy services.

- In CY 2004, per member per month expenditures for CHIP Phase I children were over $30 higher than those for CHIP Phase II children.

- CHIP Phase II children have utilization rates that are either similar to CHIP Phase I children or below CHIP Phase I for all service categories. These differences in utilization explain at least some of the difference in PMPM expenditures between the programs.

- Except for hospital services (where the age groups are relatively equal), teenagers are responsible for higher average claim costs than younger children.

- The most expensive service for both CHIP Phase I and CHIP Phase II children (measured on a per member per month basis) is pharmacy services. The same is true for children in Medicaid, although mental health services are almost as high for Medicaid children, whereas they represent less than 10% of total service payments in the CHIP budget.

KEY FINDINGS RELATED TO QUALITY

- Overall, children in CHIP continue to give high ratings in the annual member satisfaction survey. In most areas studied, Indiana's CHIP members give higher marks than CHIP members in other programs nationwide. In rating their child's health plan, more than 90% of parents of CHIP children in both PCCM and RBMC rated it as "excellent" or "very good". Similar findings occurred for the rating of their child's personal doctor.

- Satisfaction among PMP providers, as found in their annual survey, has gone down slightly (37% were at least somewhat dissatisfied). Areas cited that caused the dissatisfaction rating were the increasing patient loads of Hoosier Healthwise members and reimbursement rates.

- When compared to national HEDIS trends for Medicaid managed care plans, Indiana's MCOs rank consistently with national figures on children's access to primary care and well-child visits. Areas for improvement for Indiana's health plans are related to immunization rates.

- The percentage of calls to the Hoosier Healthwise Member Helpline with respect to quality remain consistently low, as only 2% of all calls were related to quality issues. This has been a consistent finding for the last five years.

- The Quality Improvement Committee has been focused in the last year on improving shadow claims submissions by the MCOs as well as gaining a better understanding of who is using emergency room services and whether or not some of these members can be guided to other locations to receive services when they are non-emergent.

RECOMMENDATIONS FOR FURTHER RESEARCH

This evaluation of Indiana's CHIP program has identified areas that the CHIP Office may wish to explore to gain a better understanding of trends occurring in the program:

1. ***Develop a targeted outreach to increase well-child visit and immunization rates.*** Most of the MCOs in the RBMC delivery system as well as Prime*Step* (the PCCM program) found that the rate of well-child visits for all age groups were in line with median levels for other Medicaid managed care plans nationwide. Immunization rates, however, were often below national levels (at least as reported). One issue with the immunization rates reported is that they are not all reported directly to the Office of Medicaid Policy and Planning (which oversees Hoosier Healthwise) or to the CHIP Office. Many immunizations are conducted and recorded through the Indiana Department of Health. Although the implementation of an immunization registry has shown marked improvement in the immunization rates, the finding that these rates are below national levels may not be that the immunizations did not occur. Rather, it may be that they just have not been reported to the OMPP and the CHIP Office.

   EP&P recommends that the CHIP Office closely monitor the efforts of the managed care plan organizations in developing a targeted outreach program to parents of children enrolled in CHIP to encourage getting their children immunized and to receive an annual well-child visit as well as to follow-up on whether these took place. The MCOs have developed a mailing to parents of children in the target population who are due for recommended immunizations—namely, children that are infants through age two. As of December 2004, there were 2,484 children in this age group in CHIP Phase I and 2,655 children in CHIP Phase II.

   The CHIP Office is encouraged to measure the impact of these mailings by determining if immunizations appear in utilization data after the outreach was conducted to parents. If, for

example, immunizations were not given within three months of the targeted mailing, the CHIP Office should work with the MCOs to make follow-up calls to the parents and PMPs of children who have not been immunized.

From the primary source information gathered, a study could be conducted to see whether or not this information is being captured by the OMPP data warehouse. For those children whose parents indicated that they had received their immunizations, a search could be done in the data warehouse to see if the claim was submitted by the provider or the MCO for when the immunization took place. The purpose of this would be to see what the potential percentage of missing data exists that is not being captured by the OMPP because the immunizations are being administered by the Department of Health.

By doing this, when immunization trends are compared for Indiana's Medicaid/CHIP child population versus national NQCA data, if Indiana's data is lower than national averages, one can determine what the potential may be for incomplete reporting.

2. ***Track children originally enrolled in the Fee For Service (FFS) delivery system to their final "medical home".*** The policy in Hoosier Healthwise is that upon being informed that they are eligible for CHIP, a child's parents have up to 30 days to decide who the child's PMP will be. As a result, most children are temporarily enrolled in the FFS delivery system upon first being determined eligible for CHIP or Medicaid. By adding two new MCOs in January 2005 and adding more counties to be mandatory RBMC enrollment counties, the OMPP and CHIP have already made great strides in reducing the number of children that are enrolled in FFS even temporarily.

   EP&P has found, however, that the eligibility data is showing that some children are remaining in FFS for more than 30 days, possibly many months. *EP&P recommends that, for those still enrolled in FFS beyond 30 days, the CHIP Office should work to find out whether this is a data reporting issue or if children are in fact still in FFS. If children are remaining in FFS beyond 30 days, the CHIP Office should aim to understand the reason why this is occurring.* Specific recommended steps are detailed in Chapter VI of this report.

   EP&P suggests that the trends in FFS enrollment be regularly monitored. Possible steps for the CHIP Office include:

   1. Obtain from the OMPP's client eligibility system the number of new enrollees in the CHIP each month. Categorize them into the three delivery systems they enter upon first enrolling to understand what is the percentage of new members that are temporarily enrolling in FFS.

   2. For those members that enter the system in FFS, track them to determine how long it takes for them to enroll in either the RBMC or PCCM delivery systems.

3. Identify those members that are still enrolled in FFS after three months of enrollment and investigate why they are still enrolled here.

4. Chart these findings monthly to determine if the percentage of children that are initially enrolling in FFS and those that are remaining in FFS after three months is going down as the Hoosier Healthwise program overall continues to focus on moving children into the RBMC delivery system.